FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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.

I. IDPH License ID Number: 0050765

Facility Name: Lake Shore Hlthcare & Rehab

Address: 7200 N 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: 1/1/2010

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	56,469	2,613	12,866	71,948	8
9	SNF/PED					9
10	ICF	14,896		233	15,129	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	71,365	2,613	13,099	87,077	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.22%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 313 and days of care provided 7,224

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	453,652	150,872	52,150	656,674		656,674	134	656,808			1
2	Food Purchase		485,354		485,354	(39,245)	446,109	(18,801)	427,309			2
3	Housekeeping		43,631	427,227	470,858		470,858	2,262	473,120			3
4	Laundry		5,369	292,615	297,984		297,984		297,984			4
5	Heat and Other Utilities			337,067	337,067		337,067	(8,107)	328,960			5
6	Maintenance	124,327	26,444	129,789	280,560		280,560	27,850	308,410			6
7	Other (specify):*											7
8	TOTAL General Services	577,979	711,670	1,238,848	2,528,497	(39,245)	2,489,252	3,338	2,492,591			8
	B. Health Care and Programs											
9	Medical Director			122,254	122,254		122,254	13,067	135,321			9
10	Nursing and Medical Records	4,702,580	430,338	156,214	5,289,132		5,289,132	(2,531)	5,286,601			10
10a	Therapy	228,546		6,038	234,584		234,584	(1,173)	233,411			10a
11	Activities	128,564	22,736	2,442	153,742		153,742	24	153,766			11
12	Social Services	233,741		18,790	252,531		252,531	8,873	261,404			12
13	CNA Training											13
14	Program Transportation			11,072	11,072		11,072		11,072			14
15	Other (specify):*							8,775	8,775			15
16	TOTAL Health Care and Programs	5,293,431	453,074	316,810	6,063,315		6,063,315	27,035	6,090,350			16
	C. General Administration											
17	Administrative	169,488		600,000	769,488		769,488	(290,876)	478,612			17
18	Directors Fees											18
19	Professional Services			765,238	765,238	(1,295)	763,943	(528,261)	235,682			19
20	Dues, Fees, Subscriptions & Promotions			199,996	199,996		199,996	(120,117)	79,879			20
21	Clerical & General Office Expenses	355,761	22,487	510,410	888,658		888,658	(209,065)	679,593			21
22	Employee Benefits & Payroll Taxes			1,233,449	1,233,449	39,245	1,272,694		1,272,694			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,680	2,680		2,680	263	2,943			24
25	Other Admin. Staff Transportation			7,792	7,792		7,792	6,435	14,227			25
26	Insurance-Prop.Liab.Malpractice			340,790	340,790		340,790	18,788	359,578			26
27	Other (specify):*							72,900	72,900			27
28	TOTAL General Administration	525,249	22,487	3,660,355	4,208,091	37,950	4,246,041	(1,049,933)	3,196,107			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,396,659	1,187,231	5,216,013	12,799,903	(1,295)	12,798,608	(1,019,560)	11,779,048			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lake Shore Hlthcare & Rehab #0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			606,112	606,112		606,112	383,532	989,644			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			88,915	88,915		88,915	986,860	1,075,775			32
33	Real Estate Taxes					1,295	1,295	369,602	370,897			33
34	Rent-Facility & Grounds			2,012,469	2,012,469		2,012,469	(2,012,469)				34
35	Rent-Equipment & Vehicles							717	717			35
36	Other (specify):*							205,623	205,623			36
37	TOTAL Ownership			2,707,496	2,707,496	1,295	2,708,791	(66,135)	2,642,656			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		298,025	1,349,611	1,647,636		1,647,636	(832)	1,646,804			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			655,214	655,214		655,214		655,214			42
43	Other (specify):*	73,449		79,540	152,989		152,989	(152,989)				43
44	TOTAL Special Cost Centers	73,449	298,025	2,084,365	2,455,839		2,455,839	(153,821)	2,302,018			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,470,108	1,485,256	10,007,874	17,963,238	0	17,963,238	(1,239,516)	16,723,722			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(11,446)	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	207,080	30		9
10	Interest and Other Investment Income	(13,768)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(144)	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	(20,004)	21		18
19	Entertainment				19
20	Contributions	(65,499)	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	(299,139)	21		24
25	Fund Raising, Advertising and Promotional	(53,866)	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	(331,343)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (588,129)		$	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)	(651,387)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (651,387)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,239,516)		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

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Lake Shore Hlthcare & Rehab

ID# **0050765**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (3,850)	02	1
2	Misc. Income	(1,057)	21	2
3	Veterans Expenses	(40,271)	10	3
4	Bank Charges	(11,748)	21	4
5	Marketing Salaries	(73,449)	43	5
6	Marketing Consultant	(79,540)	43	6
7	Theft & Loss	(6,872)	21	7
8	Medicare Sequestration	(55,616)	21	8
9	Marketing Travel	(11)	25	9
10	Non-Allowable Legal Services	(8,322)	19	10
11	Additional R&M	17,961	06	11
12	Building Company Amortization	(13,150)	31	12
13	Jury Duty	(150)	10	13
14	Building Company Professional Fees	(6,225)	19	14
15	Building Company Licenses	(140)	20	15
16	PAC Dues	(7,626)	20	16
17	PPA - Food	(14,807)	02	17
18	PPA Expense	(8,379)	21	18
19	PPA - Occupational Therapist	(1,173)	10a	19
20	PPA - Medical Supplies	(16,918)	10	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**	(331,343)		49

Lake Shore Hlthcare & Rehab

ID# 0050765

Report Period Beginning: 01/01/14

Ending: 12/31/14

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			134									134	1
2	Food Purchase	(18,801)											(18,801)	2
3	Housekeeping			2,262									2,262	3
4	Laundry													4
5	Heat and Other Utilities	(11,446)		2,396	943								(8,107)	5
6	Maintenance	17,961	1,045	8,480	364								27,850	6
7	Other (specify):*													7
8	**TOTAL General Services**	(12,286)	1,045	13,272	1,307								3,338	8
	B. Health Care and Programs													
9	Medical Director			13,067									13,067	9
10	Nursing and Medical Records	(57,339)		54,808									(2,531)	10
10a	Therapy	(1,173)											(1,173)	10a
11	Activities			24									24	11
12	Social Services			8,873									8,873	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			8,775									8,775	15
16	**TOTAL Health Care and Programs**	(58,512)		85,547									27,035	16
	C. General Administration													
17	Administrative			192,969		(483,845)							(290,876)	17
18	Directors Fees													18
19	Professional Services	(14,547)	6,225	(521,266)	791	536							(528,261)	19
20	Fees, Subscriptions & Promotions	(127,131)	140	6,854	20								(120,117)	20
21	Clerical & General Office Expenses	(402,815)		193,613	70	67							(209,065)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			263									263	24
25	Other Admin. Staff Transportation	(11)		1,636		4,810							6,435	25
26	Insurance-Prop.Liab.Malpractice		17,624	737	427								18,788	26
27	Other (specify):*			72,900									72,900	27
28	**TOTAL General Administration**	(544,504)	23,989	(52,294)	1,308	(478,432)							(1,049,933)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(615,302)	25,034	46,525	2,615	(478,432)							(1,019,560)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	207,080	161,900	10,296	4,256								383,532	30
31	Amortization of Pre-Op. & Org.	(13,150)	13,150											31
32	Interest	(13,768)	991,856	214	8,558								986,860	32
33	Real Estate Taxes		362,665		6,937								369,602	33
34	Rent-Facility & Grounds		(2,012,469)	30,558	(30,558)								(2,012,469)	34
35	Rent-Equipment & Vehicles			717									717	35
36	Other (specify):*		205,623										205,623	36
37	TOTAL Ownership	180,162	(277,275)	41,785	(10,807)								(66,135)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(832)						(832)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(152,989)											(152,989)	43
44	TOTAL Special Cost Centers	(152,989)					(832)						(153,821)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(588,129)	(252,241)	88,310	(8,192)	(478,432)	(832)						(1,239,516)	45

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 2,012,469	LSH Property LLC		$	$ (2,012,469)	1
2	V	26	Insurance Expense		LSH Property LLC		17,624	17,624	2
3	V	32	Interest	360	LSH Property LLC		992,216	991,856	3
4	V	30	Depreciation Expense		LSH Property LLC		161,900	161,900	4
5	V	31	Amortization Expense		LSH Property LLC		13,150	13,150	5
6	V	33	Real Estate Tax Expense		LSH Property LLC		362,665	362,665	6
7	V	19	Legal & Professional		LSH Property LLC		6,225	6,225	7
8	V	36	Mortgage Insurance		LSH Property LLC		205,623	205,623	8
9	V	20	Licenses		LSH Property LLC		140	140	9
10	V	06	R&M		LSH Property LLC		1,045	1,045	10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,012,829			$ 1,760,588	$ * (252,241)	14

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1	DIETARY	$	MANAGCARE, INC.	100.00%	$ 134	$ 134	15
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	2,262	2,262	16
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	2,396	2,396	17
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	8,480	8,480	18
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	13,067	13,067	19
20	V	10	NURSING SALARIES/CONSULTANT	37,560	MANAGCARE, INC.	100.00%	92,368	54,808	20
21	V	11	ACTIVITIES		MANAGCARE, INC.	100.00%	24	24	21
22	V	12	SOCIAL SERVICE SALARIES		MANAGCARE, INC.	100.00%	8,873	8,873	22
23	V	15	NURSING EMP BENS & PR TAXES		MANAGCARE, INC.	100.00%	8,775	8,775	23
24	V	17	ADMINISTRATIVE SALARIES		MANAGCARE, INC.	100.00%	192,969	192,969	24
25	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	8,234	8,234	25
26	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	6,854	6,854	26
27	V	21	CLERICAL AND GENERAL SALARIES		MANAGCARE, INC.	100.00%	180,493	180,493	27
28	V	21	CLERICAL AND GENERAL EXP		MANAGCARE, INC.	100.00%	13,120	13,120	28
29	V	24	SEMINARS		MANAGCARE, INC.	100.00%	263	263	29
30	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	1,636	1,636	30
31	V	26	INSURANCE		MANAGCARE, INC.	100.00%	737	737	31
32	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	72,900	72,900	32
33	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	10,296	10,296	33
34	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	214	214	34
35	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	30,558	30,558	35
36	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	717	717	36
37	V	19	BOOKKEEPING FEES	394,380	MANAGCARE, INC.	100.00%		(394,380)	37
38	V	19	ADMINISTRATIVE CONSULTANT	135,120	MANAGCARE, INC.	100.00%		(135,120)	38
39	Total			$ 567,060			$ 655,370	$ * 88,310	39

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	5	UTILITIES	$	4600 TOUHY, LLC	100.00%	$ 943	$ 943	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	364	364	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	791	791	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	20	20	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	70	70	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	427	427	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	4,256	4,256	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	8,558	8,558	22
23	V	33	REAL ESTATE TAXES		4601 TOUHY, LLC	100.00%	6,937	6,937	23
24	V								24
25	V	34	RENT	30,558	4601 TOUHY, LLC	100.00%		(30,558)	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			$ 30,558			$ 22,366	$ * (8,192)	39

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE SALARY - NATH	$	TETRAD MANAGEMENT, LLC	100.00%	$ 35,740	$ 35,740	15
16	V	17	ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	35,740	35,740	16
17	V	17	ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	35,740	35,740	17
18	V	17	ADMINISTRATIVE FEES - ELI DAVIS		TETRAD MANAGEMENT, LLC	100.00%	8,935	8,935	18
19	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	536	536	19
20	V	21	OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	67	67	20
21	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	4,810	4,810	21
22	V								22
23	V	17	MANAGEMENT FEES	600,000	TETRAD MANAGEMENT, LLC	100.00%		(600,000)	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			$ 600,000			$ 121,568	$ * (478,432)	39

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	39	Ambulance	$ 3,584	Lifeline Ambulance	100.00%	$ 2,752	$ (832)	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			$ 3,584			$ 2,752	$ * (832)	39

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Administrative	0%	See Attached	8.58	17.88%	Alloc Fees	$ 35,740	17-7	1
2	Moshe Davis	Relative	Administrative	0%	See Attached	7.86	17.86%	Alloc Fees	35,740	17-7	2
3	Yehoshua Davis	Relative	Administrative	0%	See Attached	8.58	17.88%	Alloc Fees	35,740	17-7	3
4	Eli Davis	Relative	Administrative	0%	See Attached	7.15	17.88%	Alloc Fees	8,935	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 116,155		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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
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	1	DIETARY	PATIENT DAYS	487,280	10	$ 748	$	87,077	$ 134	1
2	3	HOUSEKEEPING	PATIENT DAYS	487,280	10	12,659		87,077	2,262	2
3	5	UTILITIES	PATIENT DAYS	487,280	10	13,409		87,077	2,396	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	487,280	10	47,454		87,077	8,480	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	487,280	10	73,125		87,077	13,067	5
6	10	NURSING SALARIES	PATIENT DAYS	487,280	10	516,890	516,890	87,077	92,368	6
7	11	ACTIVITIES	PATIENT DAYS	487,280	10	136		87,077	24	7
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	487,280	10	49,654	49,654	87,077	8,873	8
9	15	NURSING EMP BENS & PR TA	PATIENT DAYS	487,280	10	49,107		87,077	8,775	9
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	487,280	10	1,079,846	1,079,846	87,077	192,969	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	46,077		87,077	8,234	11
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	487,280	10	38,354		87,077	6,854	12
13	21	CLERICAL AND GENERAL SA	PATIENT DAYS	487,280	10	1,010,032	1,010,032	87,077	180,493	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	487,280	10	73,419		87,077	13,120	14
15	24	SEMINARS	PATIENT DAYS	487,280	10	1,473		87,077	263	15
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	487,280	10	9,155		87,077	1,636	16
17	26	INSURANCE	PATIENT DAYS	487,280	10	4,123		87,077	737	17
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	487,280	10	407,944		87,077	72,900	18
19	30	DEPRECIATION	PATIENT DAYS	487,280	10	57,614		87,077	10,296	19
20	32	INTEREST EXPENSE	PATIENT DAYS	487,280	10	1,200		87,077	214	20
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	487,280	10	171,000		87,077	30,558	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	487,280	10	4,015		87,077	717	22
23										23
24										24
25	TOTALS					$ 3,667,434	$ 2,656,422		$ 655,370	25

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1 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	5	UTILITIES	MNGCR. PATIENT DAYS	487,280	10	$ 5,277	$	87,077	$ 943	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	487,280	10	2,035		87,077	364	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	487,280	10	4,429		87,077	791	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	487,280	10	148		87,077	20	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	487,280	10	391		87,077	70	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	487,280	10	2,388		87,077	427	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	487,280	10	23,819		87,077	4,256	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	487,280	10	47,891		87,077	8,558	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	487,280	10	38,818		87,077	6,937	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					$ 125,196	$		$ 22,366	25

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1 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	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	$ 200,000	$ 200,000	87,077	$ 35,740	1
2	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	200,000	200,000	87,077	35,740	2
3	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	200,000	200,000	87,077	35,740	3
4	17	ADMINISTRATIVE FEES - EL	PATIENT DAYS	487,280	10	50,000		87,077	8,935	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	3,000		87,077	536	5
6	21	OFFICE EXPENSE	PATIENT DAYS	487,280	10	374		87,077	67	6
7	25	TRAVEL	PATIENT DAYS	487,280	10	26,914		87,077	4,810	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					$ 680,288	$ 600,000		$ 121,568	25

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: Lifeline Ambulance LLC
Street Address: 2424 S. Wabash Ave
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	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	39	Ambulance	Direct Allocation			$	$		$ 2,752	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					$	$		$ 2,752	25

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Mortgage			$	$ 22,828,713			$ 979,315	1
2	Capex		X								12,900	2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Loan Payable				2,394,000			88,070	6
7	Intercompany										845	7
8	See Supplemental Schedule										8,772	8
9	TOTAL Facility Related						$	$ 25,222,713			$ 1,089,902	9
	B. Non-Facility Related*											
10	Interest Income		X								(13,767)	10
11	Bldg. Co. Interest Income		X								(360)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (14,127)	14
15	TOTALS (line 9+line14)						$	$ 25,222,713			$ 1,075,775	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 205,623** **Line # 36**

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

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 4600 Touhy		X				$	$			$ 8,558	8
9	Allocated from Managcare		X								214	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										8,772	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 Hlthcare & Rehab # 0050765 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 363,557	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.)		$ 364,682	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,125	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 368,477	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.)**		$ 1,295	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** $ 3,886 **For** 2011 **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.		$ 370,897	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	367,458	8
	2010	383,455	9
	2011	381,860	10
	2012	352,968	11
	2013	357,745	12

2014Accrual = $357,745 x 1.03 = $368,477

Allocation from 4600 Touhy LLC: $6,937

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lake Shore Hlthcare & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(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	$ 23,016.26	$ 23,016.26
2.	11-29-320-036-0000	Long Term Care Property	$ 77,785.60	$ 77,785.60
3.	11-29-320-037-0000	Long Term Care Property	$ 78,164.09	$ 78,164.09
4.	11-29-320-038-0000	Long Term Care Property	$ 78,164.09	$ 78,164.09
5.	11-29-320-039-0000	Long Term Care Property	$ 78,014.40	$ 78,014.40
6.	11-29-320-040-0000	Long Term Care Property	$ 22,600.32	$ 22,600.32
7.	See Attached	Allocated from 4600 Touhy LLC	$ 84,567.54	$ 7,556.12
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 442,312.30	$ 365,300.88

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

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

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lake Shore Hlthcare & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Allocated from 4600 Touhy, LLC			16,083	2
3	TOTALS			$ 1,237,058	3

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 17,313,657	$ 161,900	39	$ 443,940	$ 282,040	$ 2,219,700	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2010	178,413		20	13,767	13,767	61,586	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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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)		333,591			16,680	16,680	16,680	67
68	Related Party Allocations (Pages 12H & 12I)		187,349	6,036		7,837	1,801	22,575	68
69	Financial Statement Depreciation			604,756			(604,756)		69
70	TOTAL (lines 4 thru 69)		$ 18,013,010	$ 772,692		$ 482,224	$ (290,468)	$ 2,320,541	70

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 18,013,010	$ 772,692		$ 482,224	$ (290,468)	$ 2,320,541	1
2	Electrical Service To West Elevator	2011	4,200		20	420	420	1,575	2
3	New Doors- Econocare	2011	5,171		20	517	517	1,853	3
4	Custom Baseboard Covers	2011	5,706		20	1,141	1,141	3,899	4
5	Custom Baseboard Covers	2011	8,929		20	1,786	1,786	5,952	5
6	Generator Toggle Switch	2011	2,501		20	500	500	1,709	6
7	Waterproofing Membrane And Drain North Patio	2011	11,150		20	743	743	2,416	7
8	Elevator Motor Starter & Maxton Valve	2011	5,500		20	275	275	940	8
9	Flooring For Shower Room	2011	6,400		20	640	640	1,973	9
10	Foorling For Shower Room	2011	5,650		20	565	565	1,742	10
11	Econocare - Blinds, Wallcovering, Vinyl Flooring	2011	87,478		20	17,496	17,496	62,693	11
12	Activity Room - Wall, Ceiling, Light Fixtures	2011	4,603		20	230	230	901	12
13	Repaint Bathroom Doors	2011	2,600		20	130	130	498	13
14	Windows	2011	3,600		20	360	360	720	14
15	Recessed Flourescent Lighting	2012	2,740		20	137	137	274	15
16	4Th Floor Exit Door Magnetic Locks	2012	4,746		20	237	237	494	16
17	2Nd Floor Staircase Exit Door Locks	2012	5,721		20	286	286	596	17
18	Sprinkler System Heads And Pipe Fittings	2012	19,153		20	958	958	1,995	18
19	Epoxy Quartz Surface And Durock On 2Nd And 4Th Floor Showe	2012	3,200		20	160	160	333	19
20	Baseboard Covers	2012	3,547		20	177	177	369	20
21	Flooring In Resident Rooms	2012	8,551		20	428	428	891	21
22	Hvac - Sas Architects	2012	39,873		20	1,994	1,994	4,153	22
23	Idph Plan Review For Remodeling Project	2012	3,540		20	177	177	369	23
24	Walls, Floors, Cove Base, Carpet, Lighting, Tiling, Carpeting, Scor	2012	688,743		20	34,437	34,437	71,744	24
25	Walls, Flooring, Cove Base, Cornices, Plumbing, Ceiling, Locks	2012	79,588		20	3,979	3,979	8,290	25
26	Cubicle Tracks And Curtains, Cornices, Window Panels, Window	2012	2,643		20	132	132	275	26
27	Work On Doors And Door Jams	2012	2,910		20	146	146	303	27
28	Piping And Shut Off Valve	2012	4,900		20	245	245	510	28
29	Blower Motor And Temperature Control	2012	2,640		20	132	132	275	29
30	Ball Valves, Pipes, Couplings	2012	2,950		20	148	148	307	30
31	Patio Stone Surfacing	2013	8,000		20	1,600	1,600	2,533	31
32	2Nd Floor Resident Rooms & Bathrooms-Floor, Wallcovering, Lig	2013	154,358		20	15,436	15,436	24,440	32
33	A/C Wall Sleeve Units	2013	10,727		20	1,532	1,532	2,426	33
34	TOTAL (lines 1 thru 33)		$ 19,215,027	$ 772,692		$ 569,368	$ (203,324)	$ 2,527,992	34

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 19,215,027	$ 772,692		$ 569,368	$ (203,324)	$ 2,527,992	1
2	Pipes For Utility Room	2013	4,200		20	210	210	298	2
3	Bathroom - Drain Covers, Smoke Detectors, Locksets, Grab Bars	2013	36,031		20	1,802	1,802	1,952	3
4	Patient Monitoring Cabling	2014	4,484		20	374	374	374	4
5	Fire Alarm Wiring	2014	3,747		20	47	47	47	5
6	Water Heater	2014	13,900		20	579	579	579	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,277,390	$ 772,692		$ 572,379	$ (200,313)	$ 2,531,241	34

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 19,277,390	$ 772,692		$ 572,379	$ (200,313)	$ 2,531,241	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,277,390	$ 772,692		$ 572,379	$ (200,313)	$ 2,531,241	34

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 19,277,390	$ 772,692		$ 572,379	$ (200,313)	$ 2,531,241	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,277,390	$ 772,692		$ 572,379	$ (200,313)	$ 2,531,241	34

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Wallcoverings, Flooring-Corridor, Lobby, Dayroom, kitchenette, C	2014	105,536		20	5,277	5,277	5,277	9
10	Install New Aluminum Windows	2014	223,605		20	11,180	11,180	11,180	10
11	Ceiling Improvements and Window Treatments	2014	4,450		20	223	223	223	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 333,591	$		$ 16,680	$ 16,680	$ 16,680	34

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$ 333,591	$		$ 16,680	$ 16,680	$ 16,680	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 333,591	$		$ 16,680	$ 16,680	$ 16,680	34

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From 4600 Touhy LLC	2012	91,755	2,353	20	3,058	705	9,175	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated From 4600 Touhy LLC	2012	59,090	1,531	20	2,954	1,423	8,863	9
10	Allocated From 4600 Touhy LLC	2013	14,378	338	20	719	381	1,438	10
11	Allocated From 4600 Touhy LLC	2014	1,429	35	20	71	36	71	11
12	Allocated From Managcare	2013	1,540	410	20	77	(333)	154	12
13	Allocated From Managcare	2012	19,157	1,369	20	958	(411)	2,874	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 187,349	$ 6,036		$ 7,837	$ 1,801	$ 22,575	34

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12H, Carried Forward		$ 187,349	$ 6,036		$ 7,837	$ 1,801	$ 22,575	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
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 187,349	$ 6,036		$ 7,837	$ 1,801	$ 22,575	34

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

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 2,107,836	$ 7,470	$ 408,062	$ 400,592	10	$ 1,717,943	71
72	Current Year Purchases	58,617	1,355	6,751	5,396	10	6,751	72
73	Fully Depreciated Assets	48,014				10	48,014	73
74								74
75	TOTALS	$ 2,214,467	$ 8,825	$ 414,813	$ 405,988		$ 1,772,708	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	2014	$ 21,597	$ 1,046	$ 2,451	$ 1,405	5	$ 19,749	76
77										77
78										78
79										79
80	TOTALS			$ 21,597	$ 1,046	$ 2,451	$ 1,405		$ 19,749	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 22,750,511	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 782,563	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 989,643	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 207,080	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,323,698	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	Construction In Progress	$ 28,639	92
93			93
94			94
95		$ 28,639	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 Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 717 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.

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 346,547	$		$ 346,547	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			257,856			257,856	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			633,424			633,424	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				275,243		275,243	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					111,784	22,782		134,566	13
14	TOTAL			$		$ 1,349,611	$ 298,025		$ 1,647,636	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.

STATE OF ILLINOIS

Facility Name & ID Number Lake Shore Hlthcare & Rehab # 0050765 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 238,672	$ 287,598	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,810,855	5,810,855	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	173,626	188,137	6
7	Other Prepaid Expenses	15,811	60,823	7
8	Accounts Receivable (owners or related parties)	29,924	2,514,518	8
9	Other(specify):	14,237	14,237	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,283,125	$ 8,876,168	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,198,827	13
14	Buildings, at Historical Cost		5,316,218	14
15	Leasehold Improvements, at Historical Cost	1,169,855	1,485,775	15
16	Equipment, at Historical Cost	2,562,889	2,603,291	16
17	Accumulated Depreciation (book methods)	(2,397,365)	(3,098,852)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	28,693	15,159,677	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,364,072	$ 22,664,936	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,647,197	$ 31,541,104	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,351,957	$ 2,359,383	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,962	38,962	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	294,157	294,157	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,150	27,150	31
32	Accrued Real Estate Taxes(Sch.IX-B)		368,477	32
33	Accrued Interest Payable	9,814	90,475	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,757,425	3,757,425	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,479,465	$ 6,936,029	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,394,000	2,394,000	39
40	Mortgage Payable		22,828,713	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,394,000	$ 25,222,713	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,873,465	$ 32,158,742	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,226,268)	$ (617,638)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,647,197	$ 31,541,104	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 305,581	1
2	Restatements (describe):		2
3	**Additional Management Fees**	(280,000)	3
4	**Rounding**	(5)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 25,576	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,251,844)	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)**	$ (1,251,844)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,226,268)	24 *

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 19,441,893	1
2	Discounts and Allowances for all Levels	(6,031,835)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,410,058	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,960,570	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,960,570	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	278,671	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,371	19
20	Radiology and X-Ray	6,252	20
21	Other Medical Services	4,035	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 316,329	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,767	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,767	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	10,670	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,670	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,711,394	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,528,497	31
32	Health Care	6,063,315	32
33	General Administration	4,208,091	33
	B. Capital Expense		
34	Ownership	2,707,496	34
	C. Ancillary Expense		
35	Special Cost Centers	1,800,625	35
36	Provider Participation Fee	655,214	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,963,238	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,251,844)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,251,844)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,229,136	44
45	Private Pay - Net Inpatient Revenue	587,032	45
46	Medicare - Net Inpatient Revenue	1,692,532	46
47	Other-(specify) Hospice; Veterans	663,737	47
48	Other-(specify) Insurance	237,621	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,410,058	49

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

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

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

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

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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	1,403	1,563	$ 77,157	$ 49.36	1
2	Assistant Director of Nursing	2,152	2,336	86,888	37.20	2
3	Registered Nurses	36,668	40,571	1,205,137	29.70	3
4	Licensed Practical Nurses	55,290	60,325	1,428,511	23.68	4
5	CNAs & Orderlies	163,792	179,259	1,844,972	10.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,376	15,212	228,546	15.02	8
9	Activity Director	5,468	6,426	88,495	13.77	9
10	Activity Assistants	3,968	4,445	40,069	9.01	10
11	Social Service Workers	12,546	13,812	233,741	16.92	11
12	Dietician					12
13	Food Service Supervisor	3,600	3,984	66,195	16.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,250	37,316	387,457	10.38	15
16	Dishwashers					16
17	Maintenance Workers	6,919	7,671	124,327	16.21	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,488	1,611	95,842	59.49	20
21	Assistant Administrator	1,704	1,745	73,646	42.20	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,940	16,254	355,761	21.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,625	4,088	59,915	14.66	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental S	2,140	2,230	73,449	32.94	33
34	TOTAL (lines 1 - 33)	363,329	398,848	$ 6,470,108 *	$ 16.22	34

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

** See instructions.

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	Monthly	$ 52,150	01-03	35
36	Medical Director	Monthly	122,254	09-03	36
37	Medical Records Consultant	Monthly	1,592	10-03	37
38	Nurse Consultant	Monthly	95,632	10-03	38
39	Pharmacist Consultant	Monthly	9,430	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	1,215	10a-03	41
42	Respiratory Therapy Consultant	Weekly	4,823	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	34	2,442	11-03	44
45	Social Service Consultant	Monthly	18,790	12-03	45
46	Other(specify) Quality Assurance	Monthly	12,000	10-03	46
47	MDS Consultant	Monthly	37,560	10-03	47
48					48
49	TOTAL (lines 35 - 48)	34	$ 357,888		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shai Berdugo	Administrator	0	$ 34,785
Pamela Lamb	Administrator	0	61,058
Eli Barnett	Assist. Admin.	0	1,767
Alba Galindo	Assist. Admin.	0	3,069
Shannon Jones	Assist. Admin.	0	67,253
Lucia Murillo	Assist. Admin.	0	1,557
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,488

B. Administrative - Other

Description	Amount
Tetrad Management - Management Fees	$ 600,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 600,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 27,090
See Attached	Legal	50,703
Personnel Planners	Unemployment Consultant	6,592
Managcare, Inc.	Bookkeeping	394,380
Achieve Accreditation	Insurance Consultant	26,926
Managcare, Inc.	Administrative Consultant	135,120
Provinet Solutions	Computer Services	43,042
LTC Consult	Healthcare \Cconsult	2,712
Adar	Computer Services	11,164
Legat Architects	Architectural Services	8,179
The Trecs Institute	Workforce Management	1,500
See Supplemental Schedule		57,830
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 765,238

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 230,450
Unemployment Compensation Insurance	96,324
FICA Taxes	489,345
Employee Health Insurance	313,427
Employee Meals	39,245
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	1,553
Life Insurance	1,389
Other Employee Benefits	16,688
Pension Expense	47,484
Safe Harbor Match Expense	28,498
Disability Insurance	2,496
See Supplemental Schedule	5,796
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,272,694

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	30,280
Health Care Worker Background Check	
(Indicate # of checks performed 58)	1,667
Patient Background Checks 189	3,543
Licenses & Permits	4,790
Dues & Subscrptions	32,725
Allocated From Managcare	6,854
Allocated from 4600 Touhy, LLC	20
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 79,879

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,680
Allocated From Managcare	263
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,943

**See instructions.

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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		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $23,110**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **63,175** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **655,214**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **39,245** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.