FOR BHF USE

LL1

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

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0050765

Facility Name: The Mosaic of Lakeshore

Address: 7200 N Sheridan Rd (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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	114,558	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	114,558	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	71,189	2,156	14,781	88,126	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	71,189	2,156	14,781	88,126	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.93%

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 9,193

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	503,149	117,355	47,396	667,900		667,900	114	668,014			1
2	Food Purchase		553,572		553,572	(44,740)	508,832	(3,634)	505,198			2
3	Housekeeping		18,995	454,689	473,684		473,684	1,502	475,186			3
4	Laundry		17,625	303,126	320,751		320,751		320,751			4
5	Heat and Other Utilities			342,661	342,661		342,661	(10,041)	332,620			5
6	Maintenance	107,059	30,954	125,186	263,199		263,199	9,545	272,744			6
7	Other (specify):*											7
8	**TOTAL General Services**	610,208	738,501	1,273,058	2,621,767	(44,740)	2,577,027	(2,514)	2,574,513			8
	B. Health Care and Programs											
9	Medical Director			166,000	166,000		166,000		166,000			9
10	Nursing and Medical Records	6,095,188	324,761	209,384	6,629,333		6,629,333	24,525	6,653,858			10
10a	Therapy	171,453		14,759	186,212		186,212		186,212			10a
11	Activities	199,217	20,479	3,334	223,030		223,030		223,030			11
12	Social Services	244,912		37,560	282,472		282,472	9,968	292,440			12
13	CNA Training											13
14	Program Transportation			8,910	8,910		8,910		8,910			14
15	Other (specify):*							22,792	22,792			15
16	**TOTAL Health Care and Programs**	6,710,770	345,240	439,947	7,495,957		7,495,957	57,286	7,553,243			16
	C. General Administration											
17	Administrative	264,999		746,316	1,011,315		1,011,315	(641,459)	369,856			17
18	Directors Fees											18
19	Professional Services			739,246	739,246		739,246	(579,986)	159,260			19
20	Dues, Fees, Subscriptions & Promotions			153,575	153,575		153,575	(107,560)	46,015			20
21	Clerical & General Office Expenses	432,147	37,611	1,398,088	1,867,846		1,867,846	(1,088,563)	779,283			21
22	Employee Benefits & Payroll Taxes			1,350,606	1,350,606	44,740	1,395,346		1,395,346			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,893	2,893		2,893	1,692	4,585			24
25	Other Admin. Staff Transportation			8,484	8,484		8,484	7,603	16,087			25
26	Insurance-Prop.Liab.Malpractice			589,330	589,330		589,330	4,842	594,172			26
27	Other (specify):*							78,452	78,452			27
28	**TOTAL General Administration**	697,146	37,611	4,988,538	5,723,295	44,740	5,768,035	(2,324,981)	3,443,054			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,018,124	1,121,352	6,701,543	15,841,019		15,841,019	(2,270,209)	13,570,810			29

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

Facility Name & ID Number The Mosaic of Lakeshore #0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			294,200	294,200		294,200	420,815	715,015			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			96,765	96,765		96,765	913,491	1,010,256			32
33	Real Estate Taxes							386,966	386,966			33
34	Rent-Facility & Grounds			2,199,286	2,199,286		2,199,286	(2,195,346)	3,940			34
35	Rent-Equipment & Vehicles			15,182	15,182		15,182	931	16,113			35
36	Other (specify):*			62,238	62,238		62,238	82,047	144,285			36
37	TOTAL Ownership			2,667,671	2,667,671		2,667,671	(391,096)	2,276,575			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		430,426	2,068,342	2,498,768		2,498,768	(1,175)	2,497,593			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			642,329	642,329		642,329		642,329			42
43	Other (specify):*	135,445		75,120	210,565		210,565	(210,565)	(0)			43
44	TOTAL Special Cost Centers	135,445	430,426	2,785,791	3,351,662		3,351,662	(211,740)	3,139,922			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,153,569	1,551,778	12,155,005	21,860,352		21,860,352	(2,873,046)	18,987,306			45

***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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(13,226)	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	206,310	30		9
10	Interest and Other Investment Income	(7,164)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(134)	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	(29,393)	21		18
19	Entertainment				19
20	Contributions	(56,625)	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	(1,134,208)	21		24
25	Fund Raising, Advertising and Promotional	(40,586)	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	(1,222,982)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,298,008)		$	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)	(575,038)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (575,038)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,873,046)		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

The Mosaic of Lakeshore

ID# 0050765

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Building Company- Appraisal Costs	$ (11,690)	21	1
2	Building Company- Accounting Fees	(9,019)	19	2
3	Building Company- Bank Charges	(539)	21	3
4	Building Company- Amortization	(10,191)	36	4
5	Vending Income	(3,500)	02	5
6	Veterans Medical Expense	(19,360)	10	6
7	Marketing	(75,120)	43	7
8	Bank Charges	(16,042)	21	8
9	Marketing Salaries	(135,445)	43	9
10	Theft and Loss	(111)	21	10
11	Sequestration	(104,936)	21	11
12	Amortization	(62,238)	36	12
13	Additional R&M	4,237	06	13
14	Non - Allowable Expense (Tetrad)	(746,316)	17	14
15	Non - Allowable Legal	(9,581)	19	15
16	Miscellaneous Income	(1,388)	21	16
17	Medical Records Income	(5,668)	10	17
18	Non - Allowable Consultant	(4,950)	21	18
19	PAC Dues	(11,125)	20	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,222,982)		49

The Mosaic of Lakeshore

ID# 0050765

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			114									114	1
2	Food Purchase	(3,634)											(3,634)	2
3	Housekeeping			1,502									1,502	3
4	Laundry													4
5	Heat and Other Utilities	(13,226)		2,636	549								(10,041)	5
6	Maintenance	4,237		3,316	1,466		526						9,545	6
7	Other (specify):*													7
8	**TOTAL General Services**	(12,623)		7,568	2,015		526						(2,514)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(25,028)		49,554									24,525	10
10a	Therapy													10a
11	Activities													11
12	Social Services			9,968									9,968	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			22,792									22,792	15
16	**TOTAL Health Care and Programs**	(25,028)		82,314									57,286	16
	C. General Administration													
17	Administrative	(746,316)		104,857									(641,459)	17
18	Directors Fees													18
19	Professional Services	(18,600)	9,019	(200,896)	210		(369,719)						(579,986)	19
20	Fees, Subscriptions & Promotions	(108,336)		723	53								(107,560)	20
21	Clerical & General Office Expenses	(1,303,257)	12,188	82,142	38		120,325						(1,088,563)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			342			1,350						1,692	24
25	Other Admin. Staff Transportation			1,022			6,581						7,603	25
26	Insurance-Prop.Liab.Malpractice		3,202	829	354		457						4,842	26
27	Other (specify):*			58,245			20,207						78,452	27
28	**TOTAL General Administration**	(2,176,509)	24,409	47,263	655		(220,799)						(2,324,981)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,214,160)	24,409	137,145	2,670		(220,273)						(2,270,209)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	206,310	210,168		4,337								420,815	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,164)	912,736		7,919								913,491	32
33	Real Estate Taxes		378,485		8,481								386,966	33
34	Rent-Facility & Grounds		(2,199,286)	28,589	(28,589)		3,940						(2,195,346)	34
35	Rent-Equipment & Vehicles			931									931	35
36	Other (specify):*	(72,429)	154,476										82,047	36
37	TOTAL Ownership	126,717	(543,421)	29,520	(7,852)		3,940						(391,096)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(1,175)							(1,175)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(210,565)											(210,565)	43
44	TOTAL Special Cost Centers	(210,565)				(1,175)							(211,740)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,298,008)	(519,012)	166,665	(5,182)	(1,175)	(216,333)						(2,873,046)	45

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 2,199,286	LSH Property LLC	100.00%	$	$ (2,199,286)	1
2	V	32	Interest	383	LSH Property LLC	100.00%	913,119	912,736	2
3	V	21	Miscellaneous Income	41	LSH Property LLC	100.00%		(41)	3
4	V	30	Depreciation		LSH Property LLC	100.00%	210,168	210,168	4
5	V	26	Insurance		LSH Property LLC	100.00%	3,202	3,202	5
6	V	21	Appraisal Fees		LSH Property LLC	100.00%	11,690	11,690	6
7	V	19	Accounting Fees		LSH Property LLC	100.00%	9,019	9,019	7
8	V	36	MIP Insurance		LSH Property LLC	100.00%	144,285	144,285	8
9	V	21	Bank Charges		LSH Property LLC	100.00%	539	539	9
10	V	36	Amortization		LSH Property LLC	100.00%	10,191	10,191	10
11	V	33	Real Estate Taxes		LSH Property LLC	100.00%	378,485	378,485	11
12	V								12
13	V								13
14	Total			$ 2,199,710			$ 1,680,698	$ * (519,012)	14

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$	MOSAIC HEALTHCARE	100.00%	$ 114	$ 114	15
16	V	3	HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	1,502	1,502	16
17	V	5	UTILITIES		MOSAIC HEALTHCARE	100.00%	2,636	2,636	17
18	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	3,316	3,316	18
19	V	10	NURSING SALARIES		MOSAIC HEALTHCARE	100.00%	105,894	105,894	19
20	V	12	SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	9,968	9,968	20
21	V	15	NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	22,792	22,792	21
22	V	17	ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	104,857	104,857	22
23	V	19	PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	3,247	3,247	23
24	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	723	723	24
25	V	21	CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE	100.00%	191,228	191,228	25
26	V	21	CLERICAL AND GENERAL EXP	132,583	MOSAIC HEALTHCARE	100.00%	23,497	(109,086)	26
27	V	24	SEMINARS		MOSAIC HEALTHCARE	100.00%	342	342	27
28	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	1,022	1,022	28
29	V	26	INSURANCE		MOSAIC HEALTHCARE	100.00%	829	829	29
30	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	58,245	58,245	30
31	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	28,589	28,589	31
32	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	931	931	32
33	V	19	BOOKKEEPING FEES	110,243	MOSAIC HEALTHCARE	100.00%		(110,243)	33
34	V	19	ADMIN. CONSULTANT	93,900	MOSAIC HEALTHCARE	100.00%		(93,900)	34
35	V	10	MDS CONSULTANT	56,340	MOSAIC HEALTHCARE	100.00%		(56,340)	35
36	V				MOSAIC HEALTHCARE	100.00%			36
37	V								37
38	V								38
39	Total			$ 393,066			$ 559,731	$ * 166,665	39

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	549	$ 549	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	1,466	1,466	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	210	210	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	53	53	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	38	38	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	354	354	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	4,337	4,337	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	7,919	7,919	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	8,481	8,481	23
24	V								24
25	V	34	RENT	28,589	4600 TOUHY, LLC	100.00%		(28,589)	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			$ 28,589			$ 23,407	$ * (5,182)	39

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 8,909	LIFELINE AMBULANCE	4.00%	$ 7,734	$ (1,175)	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			$ 8,909			$ 7,734	$ * (1,175)	39

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	6	MAINTENANCE & REPAIR	$	PLATINUM BILLING SOLUTIONS	30.00%	$ 526	$ 526	15
16	V	19	PROFESSIONAL SERVICES		PLATINUM BILLING SOLUTIONS	30.00%	2,783	2,783	16
17	V	21	CLERICAL & GENERAL		PLATINUM BILLING SOLUTIONS	30.00%	18,621	18,621	17
18	V	21	CLERICAL & GENERAL- SALARY		PLATINUM BILLING SOLUTIONS	30.00%	101,704	101,704	18
19	V	24	BUSINESS SEMINAR		PLATINUM BILLING SOLUTIONS	30.00%	1,350	1,350	19
20	V	25	AUTO & TRAVEL		PLATINUM BILLING SOLUTIONS	30.00%	6,581	6,581	20
21	V	26	INSURANCE		PLATINUM BILLING SOLUTIONS	30.00%	457	457	21
22	V	27	EMPLOYEE BENEFITS/TAXES		PLATINUM BILLING SOLUTIONS	30.00%	20,207	20,207	22
23	V	34	RENT		PLATINUM BILLING SOLUTIONS	30.00%	3,940	3,940	23
24	V								24
25	V	19	AR MANAGEMENT SERVICES	372,502	PLATINUM BILLING SOLUTIONS	30.00%		(372,502)	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			$ 372,502			$ 156,169	$ * (216,333)	39

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	TETRAD MANAGEMENT	0.52%	MOSAIC OF BEACON	CHICAGO	LSH PROPERTY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	LAKE SHORE YD DELTA, LLC	99.48%	MOSAIC OF MAYFIELD	CHICAGO	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	MANAGEMENT CO	2
3			MOSAIC OF UPTOWN	CHICAGO	4600 TOUHY LLC	LINCOLNWOOD	BUILDING CO.	3
4			MOSAIC OF SPRINGFIELD	SPRINGFIELD, IL	MOSAIC HC	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	PLATINUM BILLING SOLUTION	LAKEWOOD, NJ	AR MANAGEMENT SERVICI	6
7			MORTON VILLA HEALTHCARE & REHABILTATION CENTRE	MORTON, IL	WORTHY INSURANCE GROUP I	SKOKIE	INSURANCE	7
8			MORTON TERRACE HEALTHCARE & REHABILITATION CENTRE	MORTON, IL				8
9			RIVERSHORES HEALTHCARE & 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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		13

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1 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	483,176	10	$ 625	$	88,126	$ 114	1
2	3	HOUSEKEEPING	PATIENT DAYS	483,176	10	8,235		88,126	1,502	2
3	5	UTILITIES	PATIENT DAYS	483,176	10	14,454		88,126	2,636	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	483,176	10	18,179		88,126	3,316	4
5	10	NURSING SALARIES	PATIENT DAYS	483,176	10	580,592	580,592	88,126	105,894	5
6	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	483,176	10	54,655	54,655	88,126	9,968	6
7	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	483,176	10	124,964		88,126	22,792	7
8	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	483,176	10	574,906	574,906	88,126	104,857	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	483,176	10	17,800		88,126	3,247	9
10	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	483,176	10	3,962		88,126	723	10
11	21	CLERICAL AND GENERAL SAI	PATIENT DAYS	483,176	10	1,048,463	1,048,463	88,126	191,228	11
12	21	CLERICAL AND GENERAL EX	PATIENT DAYS	483,176	10	128,829		88,126	23,497	12
13	24	SEMINARS	PATIENT DAYS	483,176	10	1,876		88,126	342	13
14	25	ADMIN. STAFF TRANS.	PATIENT DAYS	483,176	10	5,603		88,126	1,022	14
15	26	INSURANCE	PATIENT DAYS	483,176	10	4,543		88,126	829	15
16	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	483,176	10	319,345		88,126	58,245	16
17	34	RENT - BUILDING (RELATED)	PATIENT DAYS	483,176	10	156,750		88,126	28,589	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	483,176	10	5,104		88,126	931	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,068,885	$ 2,258,616		$ 559,731	25

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	483,176	10	3,010		88,126	549	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	483,176	10	8,036		88,126	1,466	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	483,176	10	1,150		88,126	210	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	483,176	10	293		88,126	53	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	483,176	10	209		88,126	38	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	483,176	10	1,941		88,126	354	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	483,176	10	23,779		88,126	4,337	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	483,176	10	43,419		88,126	7,919	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	483,176	10	46,499		88,126	8,481	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					$ 128,334	$		$ 23,407	25

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$	$		$ 7,734	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					$	$		$ 7,734	25

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: PLATINUM BILLING SOLUTIONS
Street Address: 1100 TOWBIN AVENUE, UNIT C
City / State / Zip Code: LAKEWOOD, NJ 08701
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	6	MAINTENANCE & REPAIR	PATIENT DAYS	483,176	10	$ 2,885	$	88,126	$ 526	1
2	19	PROFESSIONAL SERVICES	PATIENT DAYS	483,176	10	15,260		88,126	2,783	2
3	21	CLERICAL & GENERAL	PATIENT DAYS	483,176	10	102,097		88,126	18,621	3
4	21	CLERICAL & GENERAL- SALA	PATIENT DAYS	483,176	10	557,621	557,621	88,126	101,704	4
5	24	BUSINESS SEMINAR	PATIENT DAYS	483,176	10	7,400		88,126	1,350	5
6	25	AUTO & TRAVEL	PATIENT DAYS	483,176	10	36,080		88,126	6,581	6
7	26	INSURANCE	PATIENT DAYS	483,176	10	2,507		88,126	457	7
8	27	EMPLOYEE BENEFITS/TAXES	PATIENT DAYS	483,176	10	110,789		88,126	20,207	8
9	34	RENT	PATIENT DAYS	483,176	10	21,600		88,126	3,940	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					$ 856,240	$ 557,621		$ 156,169	25

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Capital One Bank		X	Mortgage			$	$ 21,997,462			$ 913,119	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	First Midwest Bank		X	Line of Credit				2,208,125			96,765	6
7	Allocated from 4600 Touhy	X									7,919	7
8					-							8
9	TOTAL Facility Related						$	$ 24,205,587			$ 1,017,803	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,163)	10
11	Interest Income - Building Co		X								(383)	11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (7,546)	14
15	TOTALS (line 9+line14)						$	$ 24,205,587			$ 1,010,257	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 144,285 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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											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 The Mosaic of Lakeshore # 0050765 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	353,093	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.)	$	368,864	2
3. Under or (over) accrual (line 2 minus line 1).	$	15,771	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	371,195	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	386,966	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	381,860	8
	2012	352,968	9
	2013	357,745	10
	2014	342,809	11
	2015	360,383	12

2016 Accrual = $360,383 x 1.03 = 371,195 (Rounded)

Allocation from 4600 Touhy LLC: $8,481

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Mosaic of Lakeshore COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-320-040-0000	Long Term Care Property	$ 22,767.74	$ 22,767.74
2.	11-29-320-039-0000	Long Term Care Property	$ 78,589.38	$ 78,589.38
3.	11-29-320-038-0000	Long Term Care Property	$ 78,740.18	$ 78,740.18
4.	11-29-320-037-0000	Long Term Care Property	$ 78,740.18	$ 78,740.18
5.	11-29-320-035-0000	Long Term Care Property	$ 23,186.84	$ 23,186.84
6.	11-29-320-036-0000	Long Term Care Property	$ 78,358.86	$ 78,358.86
7.	See Attached	Allocated from 4600 Touhy LLC	$ 89,919.35	$ 8,200.15
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 450,302.53	$ 368,583.33

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Mosaic of Lakeshore COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			16,415	2
3	TOTALS			$ 1,237,390	3

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 210,168	39	$ 443,940	$ 233,772	$ 3,107,580	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2010	178,413		20	10,151	10,151	83,622	9
10	Various			2011	153,487		20	13,138	13,138	124,468	10
11	Various			2012	875,445		20	43,772	43,772	178,737	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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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)		488,635			24,432	24,432	65,543	67
68	Related Party Allocations (Pages 12H & 12I)		191,216	4,336		8,001	3,665	39,041	68
69	Financial Statement Depreciation			294,200			(294,200)		69
70	TOTAL (lines 4 thru 69)		$ 19,200,853	$ 508,704		$ 543,434	$ 34,730	$ 3,598,990	70

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 19,200,853	$ 508,704		$ 543,434	$ 34,730	$ 3,598,990	1
2	Patio Stone Surfacing	2013	8,000		20	1,600	1,600	5,733	2
3	2Nd Floor Resident Rooms & Bathrooms-Floor, Wallcovering, Lig	2013	154,358		20	15,436	15,436	55,312	3
4	A/C Wall Sleeve Units	2013	10,727		20	1,532	1,532	5,491	4
5	Pipes For Utility Room	2013	4,200		20	210	210	718	5
6	Bathroom - Drain Covers, Smoke Detectors, Locksets, Grab Bars	2013	36,031		20	1,802	1,802	5,555	6
7	Patient Monitoring Cabling	2014	4,484		20	897	897	2,167	7
8	Fire Alarm Wiring	2014	3,747		20	187	187	422	8
9	Water Heater	2014	13,900		20	695	695	1,969	9
10	Call Light Sysyem	2015	3,092		20	618	618	1,185	10
11	Installation Of 2 New Annunciators For Call Lights With New Co	2015	6,184		20	309	309	541	11
12	Heat Pump	2015	4,600		20	920	920	1,533	12
13	2 Sump Pump Basins	2015	5,600		20	1,120	1,120	1,587	13
14	4 Wall Ac Wall	2015	2,723		20	545	545	817	14
15	4 Wall Ac Units	2015	2,701		20	540	540	765	15
16	Water Pump	2015	3,700		20	740	740	1,480	16
17	Elevator - Install Life Safety Repairs	2015	32,000		20	1,600	1,600	2,667	17
18	Kitchen Cabinets And Sink	2015	17,769		20	888	888	1,777	18
19	Carpet Flooring In Theater	2015	4,001		20	200	200	400	19
20	Water Chiller	2015	3,885		20	194	194	308	20
21	Storeroom Door Lever Added To Staff Washroom 1St Flr, Locks-	2015	2,550		20	128	128	255	21
22	Dayroom- Walls/Floors/Rails	2016	2,787		20	139	139	139	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)		$ 19,527,893	$ 508,704		$ 573,735	$ 65,031	$ 3,689,811	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 19,527,893	$ 508,704		$ 573,735	$ 65,031	$ 3,689,811	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		$ 19,527,893	$ 508,704		$ 573,735	$ 65,031	$ 3,689,811	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 19,527,893	$ 508,704		$ 573,735	$ 65,031	$ 3,689,811	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,527,893	$ 508,704		$ 573,735	$ 65,031	$ 3,689,811	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 19,527,893	$ 508,704		$ 573,735	$ 65,031	$ 3,689,811	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 19,527,893	$ 508,704		$ 573,735	$ 65,031	$ 3,689,811	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Wallcoverings, Flooring-Corridor, Lobby, Dayroom, kitchenette, (	2014	105,536		20	5,277	5,277	15,830	9
10	Install New Aluminum Windows	2014	223,605		20	11,180	11,180	33,541	10
11	Ceiling Improvements and Window Treatments	2014	4,450		20	223	223	668	11
12	Renovation of 2nd floor nurses station	2015	56,023		20	2,801	2,801	5,602	12
13	Elevator Replacement	2015	66,000		20	3,300	3,300	6,600	13
14	Elevator Drilling	2015	33,021		20	1,651	1,651	3,302	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 488,635	$		$ 24,432	$ 24,432	$ 65,543	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 488,635	$		$ 24,432	$ 24,432	$ 65,543	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 488,635	$		$ 24,432	$ 24,432	$ 65,543	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 4600 Touhy LLC	2012	93,649	2,401	30	3,122	721	15,608	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 4600 Touhy LLC	2012	60,310	1,553	20	3,015	1,462	15,077	9
10	Allocated from 4600 Touhy LLC	2013	14,675	345	20	734	389	2,935	10
11	Allocated from 4600 Touhy LLC	2014	1,458	37	20	73	36	219	11
12									12
13	Allocated from Mosaic	2013	1,572		20	79	79	314	13
14	Allocated from Mosaic	2012	19,552		20	978	978	4,888	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)		$ 191,216	$ 4,336		$ 8,001	$ 3,665	$ 39,041	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 191,216	$ 4,336		$ 8,001	$ 3,665	$ 39,041	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 191,216	$ 4,336		$ 8,001	$ 3,665	$ 39,041	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 872,609	$	$ 136,575	$ 136,575	10	$ 542,979	71
72	Current Year Purchases	47,036		4,704	4,704	10	4,704	72
73	Fully Depreciated Assets	1,515,351				10	1,515,351	73
74								74
75	TOTALS	$ 2,434,996	$	$ 141,279	$ 141,279		$ 2,063,033	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Mosaic	2016	$ 17,326	$	$	$	5	$ 17,326	76
77										77
78										78
79										79
80	TOTALS			$ 17,326	$	$	$		$ 17,326	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 23,217,605	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 508,704	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 715,014	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 206,310	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,770,170	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	Elevator Upgrades	$ 100,894	92
93			93
94			94
95		$ 100,894	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Allocated from Platinum				3,940			6
7	TOTAL				$ 3,940 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 931 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	Facility		$ 1,265	$ 15,182	17
18					18
19					19
20					20
21	TOTAL		$ 1,265	$ 15,182	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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 755,685	$		$ 755,685	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			328,348			328,348	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			761,479			761,479	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				372,308		372,308	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					222,830	58,118		280,948	13
14	TOTAL			$		$ 2,068,342	$ 430,426		$ 2,498,768	14

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

Facility Name & ID Number The Mosaic of Lakeshore **#** 0050765 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 3,792	$ 44,429	1
2	Cash-Patient Deposits	37,682	37,682	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,114,982	7,114,982	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	222,032	260,911	6
7	Other Prepaid Expenses	3,800	3,800	7
8	Accounts Receivable (owners or related parties)	398,816	398,816	8
9	Other(specify): See Attached Schedule	153,703	163,703	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,934,807	$ 8,024,323	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	1,215,097	1,612,739	15
16	Equipment, at Historical Cost	2,679,862	2,924,406	16
17	Accumulated Depreciation (book methods)	(3,024,629)	(4,129,579)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	235,598	15,542,055	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,105,928	$ 22,464,666	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,040,735	$ 30,488,989	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,097,077	$ 4,104,228	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,483	38,483	28
29	Short-Term Notes Payable	2,208,125	2,208,125	29
30	Accrued Salaries Payable	549,968	549,968	30
31	Accrued Taxes Payable (excluding real estate taxes)	36,658	36,658	31
32	Accrued Real Estate Taxes(Sch.IX-B)		371,195	32
33	Accrued Interest Payable	13,645	87,886	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	400,027	400,027	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,343,983	$ 7,796,570	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		21,997,462	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	3,462,025	783,443	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,462,025	$ 22,780,905	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,806,008	$ 30,577,475	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,765,273)	$ (88,486)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,040,735	$ 30,488,989	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,381,663)	1
2	Restatements (describe):		2
3	**Equity Adjustment**	(298,741)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,680,404)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(84,869)	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)**	$ (84,869)	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)**	$ (1,765,273)	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	$ 20,425,665	1
2	Discounts and Allowances for all Levels	(2,070,335)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 18,355,330	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,098,996	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,098,996	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	271,960	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,812	19
20	Radiology and X-Ray	8,665	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 303,437	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,164	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,164	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	10,556	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,556	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 21,775,483	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,621,767	31
32	Health Care	7,495,957	32
33	General Administration	5,723,295	33
	B. Capital Expense		
34	Ownership	2,667,671	34
	C. Ancillary Expense		
35	Special Cost Centers	2,709,333	35
36	Provider Participation Fee	642,329	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,860,352	40
41	**Income before Income Taxes (line 30 minus line 40)****	(84,869)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (84,869)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,558,994	44
45	Private Pay - Net Inpatient Revenue	656,318	45
46	Medicare - Net Inpatient Revenue	4,311,748	46
47	Other-(specify) Veterans/Hospice	617,871	47
48	Other-(specify) Insurance	210,399	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 18,355,330	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	2,063	2,120	$ 116,350	$ 54.88	1
2	Assistant Director of Nursing	2,029	2,189	87,223	39.85	2
3	Registered Nurses	35,681	39,181	1,160,549	29.62	3
4	Licensed Practical Nurses	87,633	95,833	2,283,622	23.83	4
5	CNAs & Orderlies	173,304	191,456	2,376,572	12.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,583	9,214	171,453	18.61	8
9	Activity Director	3,691	4,073	64,779	15.90	9
10	Activity Assistants	6,493	6,952	72,174	10.38	10
11	Social Service Workers	14,226	15,011	244,912	16.32	11
12	Dietician					12
13	Food Service Supervisor	4,076	4,397	74,303	16.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,629	39,241	428,846	10.93	15
16	Dishwashers					16
17	Maintenance Workers	5,959	6,325	107,059	16.93	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,155	2,266	188,771	83.31	20
21	Assistant Administrator	1,214	1,763	76,228	43.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,157	17,418	432,147	24.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,823	4,239	70,872	16.72	31
32	Other Health Care(specify)					32
33	Other(specify)	7,740	8,131	197,709	24.32	33
34	TOTAL (lines 1 - 33)	410,456	449,809	$ 8,153,569 *	$ 18.13	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	$ 47,396	01-03	35
36	Medical Director	Monthly	166,000	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	119,290	10-03	38
39	Pharmacist Consultant	Monthly	19,827	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Weekly	14,759	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	3,334	11-03	44
45	Social Service Consultant	Monthly	37,560	12-03	45
46	Other(specify)				46
47	MDS Consultant	Monthly	56,340	10-03	47
48					48
49	TOTAL (lines 35 - 48)	47	$ 469,306		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	365	9,127	10-03	52
53	TOTAL (lines 50 - 52)	365	$ 9,127		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yisroel Davis	Administrator	0.00%	$ 188,771
Shmuel Weinberger	Assist. Admin.	0.00%	16,813
Shannon Jones	Assist. Admin.	0.00%	44,220
Michael Donovan	Assist. Admin.	0.00%	15,195
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 264,999

B. Administrative - Other

Description	Amount
Management Fees - Tetrad	$ 746,316
TOTAL (agree to Schedule V, line 17, col. 3)	$ 746,316
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Eone Solutions	Computer Software Expense	$ 297
Smartlinx Solutions	Computer Software Expense	12,587
Provinet Solutions	Computer Software Expense	1,607
Creative Technology Solutions	Computer Software Expense	3,145
Mosaic Healthcare Inc	Computer Software Expense	1,123
Galaxy Hosted Software	Computer Software Expense	1,460
Ability Network	Computer Software Expense	6,504
Health MEDX	Computer Software Expense	44,232
Adar, LLC	Computer Software Expense	2,902
Sikich LLP	Computer Software Expense	1,391
Sysco Chicago	Computer Software Expense	351
See Supplemental Schedule		663,649
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 739,248

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 212,865
Unemployment Compensation Insurance	88,982
FICA Taxes	602,777
Employee Health Insurance	318,571
Employee Meals	44,740
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	4,028
Union Pension	50,479
401K Match	38,415
Disability Insurance	7,333
Other Employee Benefits	27,155
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,395,344

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,636
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	24,468
License and Permits	6,135
Allocated from Mosaic	723
Allocated from 4600 Touhy, LLC	53
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,016

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,893
Allocated from Mosaic	342
Allocated from Platinum	1,350
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,585

* Attach copy of IMRF notifications

**See instructions.

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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 Long Term Care: $33,713**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **55,130** 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. $ **642,329**
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. $ **44,740** 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