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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0050765

Facility Name: Mosaic Of Lakeshore

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 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 01/01/18 to 12/31/18 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, 9 Parkway North, Suite 200 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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	313	Skilled (SNF)	313	114,245	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	313	TOTALS	313	114,245	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	68,870	2,929	14,109	85,908	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	68,870	2,929	14,109	85,908	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.20%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 01/01/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2010 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 6,201

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: 12/31/2018 Fiscal Year: 12/31/2018

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

STATE OF ILLINOIS

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	624,671	66,447	50,057	741,175		741,175		741,175			1
2	Food Purchase		623,413		623,413		623,413	(3,013)	620,400			2
3	Housekeeping		21,498	673,640	695,138		695,138		695,138			3
4	Laundry		307,617		307,617		307,617		307,617			4
5	Heat and Other Utilities			458,217	458,217		458,217	(4,543)	453,674			5
6	Maintenance	100,249	28,956	93,184	222,389		222,389	24,859	247,248			6
7	Other (specify):*											7
8	**TOTAL General Services**	724,920	1,047,931	1,275,098	3,047,949		3,047,949	17,302	3,065,251			8
	B. Health Care and Programs											
9	Medical Director			130,000	130,000		130,000		130,000			9
10	Nursing and Medical Records	6,301,867	361,269	51,989	6,715,125		6,715,125	(63,606)	6,651,519			10
10a	Therapy	174,155		28,109	202,264		202,264		202,264			10a
11	Activities	220,573	29,648	2,748	252,969		252,969		252,969			11
12	Social Services	274,329			274,329		274,329		274,329			12
13	CNA Training											13
14	Program Transportation			8,095	8,095		8,095		8,095			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,970,924	390,917	220,941	7,582,782		7,582,782	(63,606)	7,519,176			16
	C. General Administration											
17	Administrative	356,607		600,000	956,607		956,607	(447,500)	509,107			17
18	Directors Fees											18
19	Professional Services			707,438	707,438	(5,253)	702,185	(204,857)	497,328			19
20	Dues, Fees, Subscriptions & Promotions			92,705	92,705		92,705	(66,378)	26,328			20
21	Clerical & General Office Expenses	241,946	28,379	393,285	663,610		663,610	(252,204)	411,406			21
22	Employee Benefits & Payroll Taxes			1,334,237	1,334,237		1,334,237		1,334,237			22
23	Inservice Training & Education											23
24	Travel and Seminar			836	836		836		836			24
25	Other Admin. Staff Transportation			16,051	16,051		16,051	470	16,521			25
26	Insurance-Prop.Liab.Malpractice			309,964	309,964		309,964	32,368	342,332			26
27	Other (specify):*							46,806	46,806			27
28	**TOTAL General Administration**	598,553	28,379	3,454,516	4,081,448	(5,253)	4,076,195	(891,296)	3,184,899			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,294,397	1,467,227	4,950,555	14,712,179	(5,253)	14,706,926	(937,600)	13,769,326			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 Mosaic Of Lakeshore #0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			78,258	78,258		78,258	580,588	658,846			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			161,210	161,210		161,210	841,212	1,002,422			32
33	Real Estate Taxes					5,253	5,253	479,794	485,047			33
34	Rent-Facility & Grounds			2,092,611	2,092,611		2,092,611	(2,092,611)				34
35	Rent-Equipment & Vehicles			15,182	15,182		15,182	282	15,464			35
36	Other (specify):*							138,382	138,382			36
37	**TOTAL Ownership**			2,347,261	2,347,261	5,253	2,352,514	(52,354)	2,300,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		371,672	1,811,696	2,183,368		2,183,368		2,183,368			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			648,647	648,647		648,647		648,647			42
43	Other (specify):*	145,965			145,965		145,965	(145,965)	0			43
44	**TOTAL Special Cost Centers**	145,965	371,672	2,460,343	2,977,980		2,977,980	(145,965)	2,832,015			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,440,362	1,838,899	9,758,159	20,037,420		20,037,420	(1,135,918)	18,901,502			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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(8,009)	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	354,773	30		9
10	Interest and Other Investment Income	(25,227)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(213)	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	(19,110)	21		18
19	Entertainment				19
20	Contributions	(61,700)	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	(194,237)	21		24
25	Fund Raising, Advertising and Promotional	(4,989)	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	(405,983)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (364,695)		$	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)	(771,223)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (771,223)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,135,918)		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

Mosaic Of Lakeshore

ID# 0050765

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Laboratory - Veterans	$ (1,468)	10	1
2	Equipment Rental - Veterans	(466)	10	2
3	Vending Income	(2,800)	02	3
4	Miscellaneous Income	(20,390)	21	4
5	Veterans Medical Expenses	(61,673)	10	5
6	Bank Charges	(31,025)	21	6
7	Marketing Salaries	(128,427)	43	7
8	Marketing Salaries Nonproductive	(17,538)	43	8
9	Theft And Loss	(300)	21	9
10	Medicare Sequester Cut	(73,859)	21	10
11	Building Company- Accounting Fees	(22,660)	19	11
12	Building Company- Bank Charges	(2,585)	21	12
13	Building Company- Amortization	(10,191)	36	13
14	Building Company- Licenses & Permits	(465)	20	14
15	Capitalized R&M	(3,900)	06	15
16	Additional R&M	24,723	06	16
17	Non-Allowable Legal Fees	(52,961)	19	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(405,983)		49

Mosaic Of Lakeshore

ID# 0050765

Report Period Beginning: 01/01/18

Ending: 12/31/18

	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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(3,013)											(3,013)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,009)			3,466								(4,543)	5
6	Maintenance	20,823		2,253	1,782								24,859	6
7	Other (specify):*													7
8	**TOTAL General Services**	9,801		2,253	5,248								17,302	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(63,606)											(63,606)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(63,606)											(63,606)	16
	C. General Administration													
17	Administrative					(447,500)							(447,500)	17
18	Directors Fees													18
19	Professional Services	(75,621)	22,660	(152,062)	165								(204,857)	19
20	Fees, Subscriptions & Promotions	(67,154)	465	312									(66,378)	20
21	Clerical & General Office Expenses	(341,506)	2,585	86,717									(252,204)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation			470									470	25
26	Insurance-Prop.Liab.Malpractice		27,420	4,683	265								32,368	26
27	Other (specify):*			46,806									46,806	27
28	**TOTAL General Administration**	(484,280)	53,130	(13,076)	430	(447,500)							(891,296)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(538,086)	53,130	(10,823)	5,678	(447,500)							(937,600)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	354,773	221,048		4,767								580,588	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(25,227)	861,396		5,042								841,212	32
33	Real Estate Taxes		471,500		8,294								479,794	33
34	Rent-Facility & Grounds		(2,092,611)	49,875	(49,875)								(2,092,611)	34
35	Rent-Equipment & Vehicles			282									282	35
36	Other (specify):*	(10,191)	148,573										138,382	36
37	**TOTAL Ownership**	319,355	(390,094)	50,157	(31,772)								(52,354)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(145,965)											(145,965)	43
44	**TOTAL Special Cost Centers**	(145,965)											(145,965)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(364,695)	(336,964)	39,334	(26,093)	(447,500)							(1,135,918)	45

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 2,092,611	LSH Property LLC		$	$ (2,092,611)	1
2	V	32	Interest	955	LSH Property LLC		862,351	861,396	2
3	V	30	Depreciation		LSH Property LLC		221,048	221,048	3
4	V	26	Insurance		LSH Property LLC		27,420	27,420	4
5	V	19	Accounting Fees		LSH Property LLC		22,660	22,660	5
6	V	36	MIP Insurance		LSH Property LLC		138,382	138,382	6
7	V	21	Bank Charges		LSH Property LLC		2,585	2,585	7
8	V	36	Amortization		LSH Property LLC		10,191	10,191	8
9	V	20	Licenses & Permits		LSH Property LLC		465	465	9
10	V	33	Real Estate Tax Expense		LSH Property LLC		471,500	471,500	10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,093,566			$ 1,756,602	$ * (336,964)	14

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V						$	$	15
16	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE		2,253	2,253	16
17	V	19	PROFESSIONAL FEES	175,905	MOSAIC HEALTHCARE		23,843	(152,062)	17
18	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE		312	312	18
19	V	21	CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE		135,730	135,730	19
20	V	21	CLERICAL AND GENERAL EXP		MOSAIC HEALTHCARE		(49,014)	(49,014)	20
21	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE		470	470	21
22	V	26	INSURANCE		MOSAIC HEALTHCARE		4,683	4,683	22
23	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE		46,806	46,806	23
24	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE		49,875	49,875	24
25	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE		282	282	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			$ 175,905			$ 215,239	$ * 39,334	39

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		3,466	$ 3,466	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC		1,782	1,782	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC		165	165	17
18	V	26	INSURANCE		4600 TOUHY, LLC		265	265	18
19	V	30	DEPRECIATION		4600 TOUHY, LLC		4,767	4,767	19
20	V	32	INTEREST EXPENSE		4600 TOUHY, LLC		5,042	5,042	20
21	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC		8,294	8,294	21
22	V	34	BUILDING RENT	49,875	4600 TOUHY, LLC			(49,875)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 49,875			$ 23,782	$ * (26,093)	39

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	N. DAVIS-GURANTEED PYMNT.	$ 600,000	TETRAD MANAGEMENT, LLC		$ 152,500	$ (447,500)	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			$ 600,000			$ 152,500	$ * (447,500)	39

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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%			LSH PROPERTY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	LAKE SHORE YD DELTA, LLC	99.48%			TETRAD MANAGEMENT, LLC	LINCOLNWOOD	MANAGEMENT CO	2
3					4600 TOUHY LLC	LINCOLNWOOD	BUILDING CO.	3
4					MOSAIC HC	LINCOLNWOOD	MANAGEMENT CO	4
5					LIFELINE AMBULANCE,LLC	CHICAGO	AMBULANCE	5
6					WORTHY INSURANCE GROUP L	SKOKIE	INSURANCE	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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Nathan Davis	Relative	Administrative	0.00%	none	35	87.50%	Guranteed P	$ 152,500	17-7	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	$ 152,500		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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
2	6	REPAIRS AND MAINT.	NATHAN DAVIS HOURS WC	40	4	2,575		35	2,253	2
3	19	PROFESSIONAL FEES	NATHAN DAVIS HOURS WC	40	4	27,249		35	23,843	3
4	20	FEES, SUBSCRIPTIONS	NATHAN DAVIS HOURS WC	40	4	356		35	312	4
5	21	CLERICAL AND GENERAL SAL	NATHAN DAVIS HOURS WC	40	4	155,120	155,120	35	135,730	5
6	21	CLERICAL AND GENERAL EXI	NATHAN DAVIS HOURS WC	40	4	(56,016)		35	(49,014)	6
7	25	ADMIN. STAFF TRANS.	NATHAN DAVIS HOURS WC	40	4	537		35	470	7
8	26	INSURANCE	NATHAN DAVIS HOURS WC	40	4	5,352		35	4,683	8
9	27	GEN. ADMIN. EMP. BEN.	NATHAN DAVIS HOURS WC	40	4	53,492		35	46,806	9
10	34	RENT - BUILDING (RELATED)	NATHAN DAVIS HOURS WC	40	4	57,000		35	49,875	10
11	35	EQUIPMENT RENTAL	NATHAN DAVIS HOURS WC	40	4	322		35	282	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					$ 245,988	$ 155,120		$ 215,239	25

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSKEEPING	NATHAN DAVIS HOURS WC	40	4	$	$	35	$	1
2	5	UTILITIES	NATHAN DAVIS HOURS WC	40	4	3,961		35	3,466	2
3	6	REPAIRS & MAINT.	NATHAN DAVIS HOURS WC	40	4	2,037		35	1,782	3
4	19	PROFESSIONAL FEES	NATHAN DAVIS HOURS WC	40	4	189		35	165	4
5	26	INSURANCE	NATHAN DAVIS HOURS WC	40	4	303		35	265	5
6	30	DEPRECIATION	NATHAN DAVIS HOURS WC	40	4	5,448		35	4,767	6
7	32	INTEREST EXPENSE	NATHAN DAVIS HOURS WC	40	4	5,763		35	5,042	7
8	33	REAL ESTATE TAXES	NATHAN DAVIS HOURS WC	40	4	9,479		35	8,294	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					$ 27,179	$		$ 23,782	25

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	N. DAVIS-GURANTEED PYMN	DIRECT ALLOCATION		1	$ 152,500	$		$ 152,500	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					$ 152,500	$		$ 152,500	25

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$	$ 21,075,485			$ 862,351	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit				2,617,497			161,210	6
7	Allocated from 4600 Touhy		X								5,042	7
8												8
9	TOTAL Facility Related						$	$ 23,692,982			$ 1,028,603	9
	B. Non-Facility Related*											
10	Interest Income		X								(25,227)	10
11	Interest Income - Building Co		X								(955)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (26,182)	14
15	TOTALS (line 9+line14)						$	$ 23,692,982			$ 1,002,421	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 138,382 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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 406,624	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.)		$ 431,658	2
3. Under or (over) accrual (line 2 minus line 1).		$ 25,034	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 454,761	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.)**		$ 5,253	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.		$ 485,048	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	357,745	8
	2014	342,809	9
	2015	360,383	10
	2016	393,901	11
	2017	423,364	12

2018 Accrual = $423,364 x 1.0742 = $454,761
Allocated from 4600 Touhy - $8,294

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mosaic Of Lakeshore COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 26,746.65	$ 26,746.65
2.	11-29-320-039-0000	Long Term Care Property	$ 92,323.61	$ 92,323.61
3.	11-29-320-038-0000	Long Term Care Property	$ 92,500.76	$ 92,500.76
4.	11-29-320-037-0000	Long Term Care Property	$ 92,500.76	$ 92,500.76
5.	11-29-320-035-0000	Long Term Care Property	$ 27,238.93	$ 27,238.93
6.	11-29-320-036-0000	Long Term Care Property	$ 92,052.81	$ 92,052.81
7.	See Attached	Allocated from 4600 Touhy	$ 94,792.62	$ 8,294.35
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 518,156.14	$ 431,657.87

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mosaic Of Lakeshore COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			15,750	2
3	TOTALS			$ 1,236,725	3

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 221,048	39	$ 443,940	$ 222,892	$ 3,995,460	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2010	178,413		20	8,008	8,008	99,876	9
10	Various			2011	153,487		20	3,701	3,701	131,869	10
11	Various			2012	875,445		20	43,772	43,772	266,281	11
12	Various			2013	213,316		20	19,646	19,646	113,035	12
13	Various			2014	22,131		20	1,779	1,779	8,116	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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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)		642,506			32,125	32,125	127,493	67
68	Related Party Allocations (Pages 12H & 12I)		266,497	4,767		11,785	7,018	80,943	68
69	Financial Statement Depreciation			78,258			(78,258)		69
70	TOTAL (lines 4 thru 69)		$ 19,665,453	$ 304,073		$ 564,757	$ 260,684	$ 4,823,073	70

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 19,665,453	$ 304,073		$ 564,757	$ 260,684	$ 4,823,073	1
2	Call Light Sysyem	2015	3,092		20	618	618	2,422	2
3	Installation Of 2 New Annunciators For Call Lights With New Cont	2015	6,184		20	309	309	1,160	3
4	Heat Pump	2015	4,600		20	920	920	3,373	4
5	2 Sump Pump Basins	2015	5,600		20	1,120	1,120	3,827	5
6	4 Wall Ac Wall	2015	2,723		20	545	545	1,906	6
7	4 Wall Ac Units	2015	2,701		20	540	540	1,846	7
8	Water Pump	2015	3,700		20	740	740	2,960	8
9	Elevator - Install Life Safety Repairs	2015	32,000		20	1,600	1,600	5,867	9
10	Kitchen Cabinets And Sink	2015	17,769		20	888	888	3,554	10
11	Carpet Flooring In Theater	2015	4,001		20	200	200	800	11
12	Water Chiller	2015	3,885		20	194	194	696	12
13	Storeroom Door Lever Added To Staff Washroom 1St Flr, Locks-R	2015	2,550		20	128	128	510	13
14	Dayroom - Walls / Floors / Rails	2016	2,787		20	139	139	406	14
15	Fire Alarm System	2017	5,894		20	295	295	589	15
16	A/C Units	2018	9,350		20	468	468	468	16
17	Plumbing-Copper Pipes & Fittings, Circulating Pump On Boiler	2018	5,960		20	298	298	298	17
18	Elevator Repair - Install New Car Sill	2018	3,900		20	195	195	195	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)		$ 19,782,149	$ 304,073		$ 573,954	$ 269,882	$ 4,853,950	34

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 19,782,149	$ 304,073		$ 573,954	$ 269,882	$ 4,853,950	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)		$ 19,782,149	$ 304,073		$ 573,954	$ 269,882	$ 4,853,950	34

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 19,782,149	$ 304,073		$ 573,954	$ 269,882	$ 4,853,950	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)		$ 19,782,149	$ 304,073		$ 573,954	$ 269,882	$ 4,853,950	34

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 19,782,149	$ 304,073		$ 573,954	$ 269,882	$ 4,853,950	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)		$ 19,782,149	$ 304,073		$ 573,954	$ 269,882	$ 4,853,950	34

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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, G	2014	105,536		20	5,277	5,277	26,384	9
10	Install New Aluminum Windows	2014	223,605		20	11,180	11,180	55,902	10
11	Ceiling Improvements and Window Treatments	2014	4,450		20	223	223	1,113	11
12	Renovation of 2nd floor nurses station	2015	56,023		20	2,801	2,801	11,204	12
13	Elevator Replacement	2015	66,000		20	3,300	3,300	13,200	13
14	Elevator Drilling	2015	33,021		20	1,651	1,651	6,604	14
15	Elevator Repairs/Renovation	2017	105,000		20	5,250	5,250	10,500	15
16	Concrete Resurfacing - Epoxy Stone Surface	2018	7,500		20	375	375	375	16
17	Install New Compressor	2018	11,500		20	575	575	717	17
18	A/C Units	2018	27,041		20	1,352	1,352	1,352	18
19	Chiller Repair	2018	2,830		20	142	142	142	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)		$ 642,506	$		$ 32,125	$ 32,125	$ 127,493	34

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 642,506	$		$ 32,125	$ 32,125	$ 127,493	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)		$ 642,506	$		$ 32,125	$	$ 127,493	34

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	4600 West Touhy LLC	2012	89,855	1,152	30	2,995	1,843	20,966	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Mosaic HC	2013	7,543		20	377	377	2,263	9
10	Mosaic HC	2012	93,802		20	4,690	4,690	32,830	10
11	4600 West Touhy LLC	2012	57,866	2,882	20	2,893	11	20,253	11
12	4600 West Touhy LLC	2013	14,080	663	20	704	41	4,224	12
13	4600 West Touhy LLC	2014	1,399	70	20	70		350	13
14	4600 West Touhy LLC	2017	279		20	14	14	15	14
15	4600 West Touhy LLC	2018	1,673		20	42	42	42	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)		$ 266,497	$ 4,767		$ 11,785	$ 7,018	$ 80,943	34

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 266,497	$ 4,767		$ 11,785	$ 7,018	$ 80,943	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)		$ 266,497	$ 4,767		$ 11,785	$ 7,018	$ 80,943	34

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 808,220	$	$ 81,863	$ 81,863	10	$ 468,904	71
72	Current Year Purchases	17,127		1,713	1,713	10	1,713	72
73	Fully Depreciated Assets	2,117,881				10	2,117,881	73
74								74
75	TOTALS	$ 2,943,228	$	$ 83,576	$ 83,576		$ 2,588,498	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Allocated from Mosaic	2018	$ 89,702	$	$ 1,316	$ 1,316	5	$ 85,753	76
77										77
78										78
79										79
80	TOTALS			$ 89,702	$	$ 1,316	$ 1,316		$ 85,753	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)	$ 24,051,804	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 304,073	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 658,846	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 354,773	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,528,201	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 282 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		$	$ 15,182	17
18					18
19					19
20					20
21	TOTAL		$	$ 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 Mosaic Of Lakeshore | STATE OF ILLINOIS # 0050765 | Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$		$ 570,480	$		$ 570,480	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			316,851			316,851	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			757,248			757,248	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				317,240		317,240	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					167,117	54,432		221,549	13
14	TOTAL			$		$ 1,811,696	$ 371,672		$ 2,183,368	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 Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.

STATE OF ILLINOIS

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 92,235	$ 207,753	1
2	Cash-Patient Deposits	46,293	46,293	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,958,093	7,958,093	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	266,121	322,413	6
7	Other Prepaid Expenses	93,019	93,019	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	187,571	1,360,034	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,643,332	$ 9,987,605	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	1,270,587	1,879,750	15
16	Equipment, at Historical Cost	2,778,580	2,971,113	16
17	Accumulated Depreciation (book methods)	(3,392,380)	(4,928,845)	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	82,986	17,595,480	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 739,773	$ 24,032,543	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,383,105	$ 34,020,148	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,882,220	$ 3,885,310	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,293	46,293	28
29	Short-Term Notes Payable	2,617,497	3,107,208	29
30	Accrued Salaries Payable	292,678	292,678	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,624	22,624	31
32	Accrued Real Estate Taxes(Sch.IX-B)		454,761	32
33	Accrued Interest Payable	17,951	89,081	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	734,804	734,804	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,614,067	$ 8,632,759	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		20,585,774	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	3,091,690	5,129,641	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,091,690	$ 25,715,415	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,705,757	$ 34,348,174	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,322,652)	$ (328,026)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,383,105	$ 34,020,148	48

*(See instructions.)

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,621,302)	1
2	Restatements (describe):		2
3	Late Journal Entry	(62)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,621,364)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	298,712	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)**	$ 298,712	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)**	$ (1,322,652)	24 *

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 19,403,948	1
2	Discounts and Allowances for all Levels	(2,053,665)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 17,350,283	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,715,454	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,715,454	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	221,847	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	131	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 221,978	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25,227	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,227	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	23,190	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 23,190	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 20,336,132	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,047,949	31
32	Health Care	7,582,782	32
33	General Administration	4,081,448	33
	B. Capital Expense		
34	Ownership	2,347,261	34
	C. Ancillary Expense		
35	Special Cost Centers	2,329,333	35
36	Provider Participation Fee	648,647	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,037,420	40
41	**Income before Income Taxes (line 30 minus line 40)****	298,712	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 298,712	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,278,245	44
45	Private Pay - Net Inpatient Revenue	763,445	45
46	Medicare - Net Inpatient Revenue	2,780,948	46
47	Other-(specify) Veterans, Hospice	1,454,106	47
48	Other-(specify) Insurance	73,539	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 17,350,283	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.**

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,984	2,208	$ 122,603	$ 55.53	1
2	Assistant Director of Nursing	2,816	2,926	123,391	42.17	2
3	Registered Nurses	31,375	33,449	1,101,438	32.93	3
4	Licensed Practical Nurses	77,141	84,170	2,431,290	28.89	4
5	CNAs & Orderlies	163,755	177,702	2,450,938	13.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,200	10,004	174,155	17.41	8
9	Activity Director	1,880	2,153	47,127	21.89	9
10	Activity Assistants	7,181	7,705	101,130	13.13	10
11	Social Service Workers	14,012	14,567	274,329	18.83	11
12	Dietician					12
13	Food Service Supervisor	3,572	4,063	79,756	19.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	37,585	41,612	544,915	13.10	15
16	Dishwashers					16
17	Maintenance Workers	4,641	4,890	100,249	20.50	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,835	3,055	285,415	93.43	20
21	Assistant Administrator	1,952	2,080	71,192	34.23	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,903	13,874	241,946	17.44	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	3,632	4,067	72,207	17.75	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	7,850	8,477	218,280	25.75	33
34	TOTAL (lines 1 - 33)	384,314	417,002	$ 8,440,361 *	$ 20.24	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	$ 50,057	01-03	35
36	Medical Director	Monthly	130,000	09-03	36
37	Medical Records Consultant	Monthly	4,044	10-03	37
38	Nurse Consultant	Monthly	11,875	10-03	38
39	Pharmacist Consultant	Monthly	24,320	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Weekly	28,109	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,748	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	MDS Consultant	Monthly	11,750	10-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 262,903		49

C. CONTRACT NURSES

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

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shannon Jones	Administrator	0	$ 285,415
Suddy Salgado-Silva	Assist. Admin.	0	71,192
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 356,607

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal Fees	$ 92,466
Platinum Billing Solutions LLC	Bookkeeping Fees	268,899
Mosaic	Bookkeeping Fees	107,500
Mosaic HC	Bookkeeping Fees	49,000
Personnel Planners Inc	Unemployment Tax Service	2,573
Marcum LLP	Accounting Fees	22,454
FMB	Accounting Fees	5,000
Cukierski & Cochrane LLC	Accounting Fees	8,600
Stout Risius Ross LLC	Real Estate Appraisal	5,003
Achieve Accreditation LLC	Accreditation Services	12,554
Mosaic HC	Insurance Consultant	8,205
See Supplemental Schedule		125,183
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 707,436

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 154,571
Unemployment Compensation Insurance	71,343
FICA Taxes	632,167
Employee Health Insurance	328,868
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	4,564
Union Pension	60,057
401K Match	62,405
Disability Insurance	3,358
Other Employee Benefits	16,900
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,334,234

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	16,644
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	3,565
Licenses and Permits	5,808
Allocated from Mosaic	312
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,329

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	836
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 836

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mosaic Of Lakeshore # 0050765 Report Period Beginning: 01/01/18 Ending: 12/31/18

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **51,562** 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. $ **648,647**
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. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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