		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0050765

Facility Name: The Mosaic of Lakeshore

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2010

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 01/01/20 to 12/31/20 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) 06/21/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	313	Skilled (SNF)	313	114,558	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	313	TOTALS	313	114,558	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	54,071	1,583	10,921	66,575	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,071	1,583	10,921	66,575	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.11%

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 5,525

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	749,549	109,909	47,300	906,758		906,758		906,758			1
2	Food Purchase		488,927		488,927		488,927	(14,464)	474,463			2
3	Housekeeping	322,192	80,938	93,293	496,423		496,423		496,423			3
4	Laundry		260,957		260,957		260,957		260,957			4
5	Heat and Other Utilities			331,637	331,637		331,637	(5,919)	325,718			5
6	Maintenance	105,644	42,464	144,086	292,194		292,194	(2,538)	289,656			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,177,385	983,195	616,316	2,776,896		2,776,896	(22,922)	2,753,975			8
	B. Health Care and Programs											
9	Medical Director			63,250	63,250		63,250		63,250			9
10	Nursing and Medical Records	5,805,738	481,905	111,612	6,399,255		6,399,255	(36,019)	6,363,236			10
10a	Therapy	177,837		4,039	181,876		181,876		181,876			10a
11	Activities	168,746	11,388	1,120	181,254		181,254		181,254			11
12	Social Services	256,621			256,621		256,621		256,621			12
13	CNA Training											13
14	Program Transportation			17,419	17,419		17,419		17,419			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,408,942	493,293	197,440	7,099,675		7,099,675	(36,019)	7,063,656			16
	C. General Administration											
17	Administrative	350,446		600,000	950,446		950,446	(550,000)	400,446			17
18	Directors Fees											18
19	Professional Services			748,192	748,192	(8,600)	739,592	14,911	754,503			19
20	Dues, Fees, Subscriptions & Promotions			89,263	89,263		89,263	(61,954)	27,309			20
21	Clerical & General Office Expenses	230,204	65,991	437,991	734,186		734,186	(177,849)	556,337			21
22	Employee Benefits & Payroll Taxes			1,198,527	1,198,527		1,198,527		1,198,527			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,379	2,379		2,379		2,379			24
25	Other Admin. Staff Transportation			2,850	2,850		2,850		2,850			25
26	Insurance-Prop.Liab.Malpractice			796,976	796,976		796,976	27,044	824,020			26
27	Other (specify):*							33,782	33,782			27
28	**TOTAL General Administration**	580,650	65,991	3,876,178	4,522,819	(8,600)	4,514,219	(714,066)	3,800,152			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,166,977	1,542,479	4,689,934	14,399,390	(8,600)	14,390,790	(773,007)	13,617,783			29

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

Facility Name & ID Number The Mosaic of Lakeshore #0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			73,550	73,550		73,550	571,017	644,567			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			142,383	142,383		142,383	800,522	942,905			32
33	Real Estate Taxes			21,904	21,904	8,600	30,504	473,836	504,341			33
34	Rent-Facility & Grounds			2,382,325	2,382,325		2,382,325	(2,382,325)				34
35	Rent-Equipment & Vehicles			20,384	20,384		20,384	(12,563)	7,821			35
36	Other (specify):*							132,011	132,011			36
37	**TOTAL Ownership**			2,640,546	2,640,546	8,600	2,649,146	(417,501)	2,231,645			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		304,623	1,254,128	1,558,751		1,558,751		1,558,751			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			539,552	539,552		539,552		539,552			42
43	Other (specify):*			30,983	30,983		30,983	(30,983)				43
44	**TOTAL Special Cost Centers**		304,623	1,824,663	2,129,286		2,129,286	(30,983)	2,098,303			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,166,977	1,847,102	9,155,143	19,169,222		19,169,222	(1,221,491)	17,947,731			45

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,035)	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	355,545	30		9
10	Interest and Other Investment Income	(26,834)	32		10
11	Discounts, Allowances, Rebates & Refunds	(10,498)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(116)	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	(68,220)	21		18
19	Entertainment				19
20	Contributions	(54,300)	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	(219,672)	21		24
25	Fund Raising, Advertising and Promotional	(8,976)	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	(206,585)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (248,691)		$	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)	(972,800)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (972,800)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,221,491)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

The Mosaic of Lakeshore

ID# 0050765

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (49,866)	21	1
2	Veterans Expense	(36,019)	10	2
3	Vending Income	(3,850)	02	3
4	Theft and Loss	(2,000)	21	4
5	Sequestration Expense	(17,202)	21	5
6	Bldg Co - Accounting Fees	(20,394)	19	6
7	Bldg Co - Bank Charges	(2,695)	21	7
8	Bldg Co - Licenses & Permits	(75)	20	8
9	Non-Allowable Expense	(30,561)	43	9
10	Non-Allowable Auto Lease	(12,563)	35	10
11	Non-Allowable Legal	(10,847)	19	11
12	Capitalized R&M	(9,900)	06	12
13	Marketing Expense	(422)	43	13
14	Bldg Co - Amortization	(10,191)	36	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
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**	(206,585)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

The Mosaic of Lakeshore

IDF 0050765

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		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

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(14,464)											(14,464)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,035)			3,116								(5,919)	5
6	Maintenance	(9,900)		5,804	1,558								(2,538)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(33,399)		5,804	4,674								(22,922)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(36,019)											(36,019)	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**	(36,019)											(36,019)	16
	C. General Administration													
17	Administrative					(550,000)							(550,000)	17
18	Directors Fees													18
19	Professional Services	(31,241)	20,394	24,869	889								14,911	19
20	Fees, Subscriptions & Promotions	(63,351)	75	499	823								(61,954)	20
21	Clerical & General Office Expenses	(359,655)	2,695	179,081	30								(177,849)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice		26,787		257								27,044	26
27	Other (specify):*			33,782									33,782	27
28	**TOTAL General Administration**	(454,247)	49,951	238,231	1,999	(550,000)							(714,066)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(523,665)	49,951	244,035	6,672	(550,000)							(773,007)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	355,545	210,024		5,448								571,017	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(26,834)	821,721		5,635								800,522	32
33	Real Estate Taxes		464,231		9,605								473,836	33
34	Rent-Facility & Grounds		(2,382,325)	58,550	(58,550)								(2,382,325)	34
35	Rent-Equipment & Vehicles	(12,563)											(12,563)	35
36	Other (specify):*	(10,191)	142,202										132,011	36
37	TOTAL Ownership	305,957	(744,147)	58,550	(37,862)								(417,501)	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):*	(30,983)											(30,983)	43
44	TOTAL Special Cost Centers	(30,983)											(30,983)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(248,691)	(694,196)	302,585	(31,189)	(550,000)							(1,221,491)	45

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 2,382,325	LSH Property LLC		$	$ (2,382,325)	1
2	V	32	Interest	886	LSH Property LLC		822,607	821,721	2
3	V	30	Depreciation Expense		LSH Property LLC		210,024	210,024	3
4	V	26	Insurance Expense		LSH Property LLC		26,787	26,787	4
5	V	19	Accounting Fees		LSH Property LLC		20,394	20,394	5
6	V	36	MIP Insurance		LSH Property LLC		132,011	132,011	6
7	V	21	Bank Charges		LSH Property LLC		2,695	2,695	7
8	V	36	Amortization		LSH Property LLC		10,191	10,191	8
9	V	20	Licenses & Permits		LSH Property LLC		75	75	9
10	V	33	Real Estate Tax Expense	21,904	LSH Property LLC		486,135	464,231	10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,405,115			$ 1,710,919	$ * (694,196)	14

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance		Mosaic Healthcare		5,804	$ 5,804	15
16	V	19	Professional Fees		Mosaic Healthcare		24,869	24,869	16
17	V	20	Fees, Subscriptions		Mosaic Healthcare		499	499	17
18	V	21	Clerical & General Salaries		Mosaic Healthcare		142,754	142,754	18
19	V	21	Clerical & General Expense		Mosaic Healthcare		36,326	36,326	19
20	V	27	Gen. Admin. Emp. Ben.		Mosaic Healthcare		33,782	33,782	20
21	V	34	Rent - Building (Related)		Mosaic Healthcare		58,550	58,550	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			$			$ 302,585	$ * 302,585	39

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		3,116	$ 3,116	15
16	V	6	Repairs & Maintenance		4600 Touhy, LLC		1,558	1,558	16
17	V	19	Professional Fees		4600 Touhy, LLC		889	889	17
18	V	20	Fees, Subscriptions		4600 Touhy, LLC		823	823	18
19	V	21	Clerical & General		4600 Touhy, LLC		30	30	19
20	V	26	Insurance		4600 Touhy, LLC		257	257	20
21	V	30	Depreciation		4600 Touhy, LLC		5,448	5,448	21
22	V	32	Interest Expense		4600 Touhy, LLC		5,635	5,635	22
23	V	33	Real Estate Taxes		4600 Touhy, LLC		9,605	9,605	23
24	V								24
25	V	34	Rent	58,550				(58,550)	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			$ 58,550			$ 27,361	$ * (31,189)	39

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Guaranteed Payment - N. Davis	$	Tetrad Management, LLC		$ 50,000	$ 50,000	15
16	V								16
17	V	17	Management Fees	600,000				(600,000)	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			$ 50,000	$ * (550,000)	39

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	40	100.00	Guranteed P	$ 250,000	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	$ 250,000		13

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	6	Repairs & Maintenance	Nathan Davis Hours Worked	40	1	5,804		40	5,804	1
2	19	Professional Fees	Nathan Davis Hours Worked	40	1	24,869		40	24,869	2
3	20	Fees, Subscriptions	Nathan Davis Hours Worked	40	1	499		40	499	3
4	21	Clerical & General Salaries	Nathan Davis Hours Worked	40	1	142,754	142,754	40	142,754	4
5	21	Clerical & General Expense	Nathan Davis Hours Worked	40	1	36,326		40	36,326	5
6	27	Gen. Admin. Emp. Ben.	Nathan Davis Hours Worked	40	1	33,782		40	33,782	6
7	34	Rent - Building (Related)	Nathan Davis Hours Worked	40	1	58,550		40	58,550	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					$ 302,585	$ 142,754		$ 302,585	25

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 4600 Touhy, LLC
Street Address 4600 W. Touhy Avenue, Suite 200
City / State / Zip Code Lincolnwood, IL 60712
Phone Number ((773) 463-1313
Fax Number ((773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Nathan Davis Hours Worked	40	1	3,116		40	3,116	1
2	6	Repairs & Maintenance	Nathan Davis Hours Worked	40	1	1,558		40	1,558	2
3	19	Professional Fees	Nathan Davis Hours Worked	40	1	889		40	889	3
4	20	Fees, Subscriptions	Nathan Davis Hours Worked	40	1	823		40	823	4
5	21	Clerical & General	Nathan Davis Hours Worked	40	1	30		40	30	5
6	26	Insurance	Nathan Davis Hours Worked	40	1	257		40	257	6
7	30	Depreciation	Nathan Davis Hours Worked	40	1	5,448		40	5,448	7
8	32	Interest Expense	Nathan Davis Hours Worked	40	1	5,635		40	5,635	8
9	33	Real Estate Taxes	Nathan Davis Hours Worked	40	1	9,605		40	9,605	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					$ 27,361	$		$ 27,361	25

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: 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	Guaranteed Payment - Nathan I	Patient Days	83,295	1	$ 50,000	$ 50,000	83,295	$ 50,000	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					$ 50,000	$ 50,000		$ 50,000	25

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Capital One Bank		X	Mortgage			$	$ 20,075,857			$ 822,607	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit				1,999,497			121,550	6
7	DOJ - Interest on Settlement		X								20,833	7
8												8
9	TOTAL Facility Related						$	$ 22,075,354			$ 964,990	9
	B. Non-Facility Related*											
10	Interest Income		X								(26,834)	10
11	Interest Income - Bldg Co.		X								(886)	11
12	Allocated from 4600 Touhy	X									5,635	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (22,085)	14
15	TOTALS (line 9+line14)						$	$ 22,075,354			$ 942,905	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 132,011 Line # 36

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 517,884	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.)		$ 494,639	2
3. Under or (over) accrual (line 2 minus line 1).		$ (23,245)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 518,986	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.)		$ 8,600	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** $ 21,904 **For** 2017 **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.		$ 504,341	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	360,383	8
	2016	393,901	9
	2017	423,364	10
	2018	476,877	11
	2019	485,033	12

2020 Accrual = $485,033 x 1.07 = $518,986

Allocated from 4600 Touhy - $9,605

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIOI	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Mosaic of Lakeshore COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 nursin 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 2019.

	(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	$ 29,970.12	$ 29,970.12
2.	11-29-320-039-0000	Long Term Care Property	$ 106,125.57	$ 106,125.57
3.	11-29-320-038-0000	Long Term Care Property	$ 106,307.39	$ 106,307.39
4.	11-29-320-037-0000	Long Term Care Property	$ 106,307.39	$ 106,307.39
5.	11-29-320-035-0000	Long Term Care Property	$ 30,475.02	$ 30,475.02
6.	11-29-320-036-0000	Long Term Care Property	$ 105,847.90	$ 105,847.90
7.	See Attached	Allocated from 4600 Touhy	$ 96,053.11	$ 9,605.31
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 581,086.50	$ 494,638.70

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Mosaic of Lakeshore COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			18,000	2
3	TOTALS			$ 1,238,975	3

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	313		2010	1972	$ 17,313,657	$ 210,024	39	$ 443,940	$ 233,915	$ 4,883,340	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2010	178,413		20	7,141	7,141	115,026	9
10	Various			2011	153,488		20	2,445	2,445	138,014	10
11	Various			2012	875,445		20	43,773	43,773	353,825	11
12	Various			2013	213,316		20	10,266	10,266	142,281	12
13	Various			2014	22,131		20	882	882	10,404	13
14	Various			2015	88,805		20	4,152	4,152	40,875	14
15	Various			2016	2,787		20	139	139	685	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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)		717,725			35,886	35,886	199,265	67
68	Related Party Allocations (Pages 12H & 12I)		305,474	5,448		13,563	8,115	119,633	68
69	Financial Statement Depreciation			73,550			(73,550)		69
70	TOTAL (lines 4 thru 69)		$ 19,871,241	$ 289,022		$ 562,187	$ 273,165	$ 6,003,348	70

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 19,871,241	$ 289,022		$ 562,187	$ 273,165	$ 6,003,348	1
2	Fire Alarm System	2017	5,894		20	295	295	1,179	2
3	A/C Units	2018	9,350		20	468	468	1,403	3
4	Plumbing-Copper Pipes & Fittings, Circulating Pump On Boiler	2018	5,960		20	298	298	894	4
5	Elevator Repair - Install New Car Sill	2018	3,900		20	195	195	585	5
6	Replace Actuator Motor	2019	3,210		20	161	161	322	6
7	2Nd Fl Shower Rm Tile, Handrails, Access Panels	2019	4,565		20	228	228	456	7
8	Repair Water Chiller	2019	3,420		20	171	171	342	8
9	Roof Coating	2019	4,700		20	235	235	470	9
10	Repair Piping In Maintenance Rm Exhaust System	2020	3,000		20	250	250	250	10
11	Fire Pump Controller Repair - Circuit Breaker	2020	3,015		20	151	151	151	11
12	Re-Pipe Hot Water Boiler, Install 3 New Shutoff Valves	2020	3,885		20	194	194	194	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)		$ 19,922,140	$ 289,022		$ 564,833	$ 275,811	$ 6,009,594	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 19,922,140	$ 289,022		$ 564,833	$ 275,811	$ 6,009,594	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)		$ 19,922,140	$ 289,022		$ 564,833	$ 275,811	$ 6,009,594	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 19,922,140	$ 289,022		$ 564,833	$ 275,811	$ 6,009,594	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)		$ 19,922,140	$ 289,022		$ 564,833	$ 275,811	$ 6,009,594	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 19,922,140	$ 289,022		$ 564,833	$ 275,811	$ 6,009,594	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)		$ 19,922,140	$ 289,022		$ 564,833	$ 275,811	$ 6,009,594	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	36,937	9
10	Install New Aluminum Windows	2014	223,605		20	11,180	11,180	78,262	10
11	Ceiling Improvements and Window Treatments	2014	4,450		20	223	223	1,558	11
12	Renovation of 2nd floor nurses station	2015	56,023		20	2,801	2,801	16,807	12
13	Elevator Replacement	2015	66,000		20	3,300	3,300	19,800	13
14	Elevator Drilling	2015	33,021		20	1,651	1,651	9,906	14
15	Elevator Repairs/Renovation	2017	105,000		20	5,250	5,250	21,000	15
16	Concrete Resurfacing - Epoxy Stone Surface	2018	7,500		20	375	375	1,125	16
17	Install New Compressor	2018	11,500		20	575	575	1,867	17
18	A/C Units	2018	27,041		20	1,352	1,352	4,056	18
19	Chiller Repair	2018	2,830		20	142	142	425	19
20	Camera System	2019	23,669		20	1,183	1,183	2,367	20
21	Compressor 25 Ton	2019	11,500		20	575	575	1,150	21
22	Water Chiller	2019	2,830		20	142	142	283	22
23	Phone System	2019	17,517		20	876	876	1,752	23
24	27 AC Units	2019	19,703		20	985	985	1,970	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)		$ 717,725	$		$ 35,886	$ 35,886	$ 199,265	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 717,725	$		$ 35,886	$ 35,886	$ 199,265	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)		$ 717,725	$		$ 35,886	$ 35,886	$ 199,265	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 4600 Touhy LLC	2012	102,692	1,317	30	3,423	2,106	30,808	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Mosaic Healthcare	2012	107,202		20	5,360	5,360	48,240	9
10	Allocated from Mosaic Healthcare	2013	8,620		20	431	431	3,449	10
11									11
12	Allocated from 4600 Touhy LLC	2012	66,133	3,294	20	3,307	13	29,760	12
13	Allocated from 4600 Touhy LLC	2013	16,092	757	20	805	48	6,437	13
14	Allocated from 4600 Touhy LLC	2014	1,599	80	20	80		559	14
15	Allocated from 4600 Touhy LLC	2017	319		20	16	16	50	15
16	Allocated from 4600 Touhy LLC	2018	1,912		20	96	96	239	16
17	Allocated from 4600 Touhy LLC	2019	905		20	45	45	91	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)		$ 305,474	$ 5,448		$ 13,563	$ 8,115	$ 119,633	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 305,474	$ 5,448		$ 13,563	$ 8,115	$ 119,633	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)		$ 305,474	$ 5,448		$ 13,563	$ 8,115	$ 119,633	34

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 781,447	$	$ 76,182	$ 76,182	10	$ 548,305	71
72	Current Year Purchases	20,485		2,049	2,049	10	2,049	72
73	Fully Depreciated Assets	2,259,929				10	2,259,929	73
74								74
75	TOTALS	$ 3,061,861	$	$ 78,231	$ 78,231		$ 2,810,283	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Mosaic	2020	$ 102,516	$	$ 1,504	$ 1,504	5	$ 101,011	76
77										77
78										78
79										79
80	TOTALS			$ 102,516	$	$ 1,504	$ 1,504		$ 101,011	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)	$ 24,325,492	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 289,022	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 644,568	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 355,545	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,920,888	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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 230 Description: See Attached
(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	2015 Ford Econoline	$ 1,265	$ 7,591	17
18					18
19					19
20					20
21	TOTAL		$ 1,265	$ 7,591	21

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$		$ 390,025	$		$ 390,025	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			182,793			182,793	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			471,893			471,893	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				256,130		256,130	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					209,417	48,493		257,910	13
14	TOTAL			$		$ 1,254,128	$ 304,623		$ 1,558,751	14

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (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	$ 222,063	$ 272,276	1
2	Cash-Patient Deposits	121,469	121,469	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,169,224	4,169,224	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	336,398	392,268	6
7	Other Prepaid Expenses	72,423	75,738	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	69,034	1,893,733	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,990,611	$ 6,924,708	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	2,847,398	3,115,150	16
17	Accumulated Depreciation (book methods)	(3,677,981)	(5,650,319)	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	1,200,747	18,692,859	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,640,751	$ 24,552,485	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,631,362	$ 31,477,193	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,127,948	$ 3,127,948	26
27	Officer's Accounts Payable	128,000	128,000	27
28	Accounts Payable-Patient Deposits	121,469	121,469	28
29	Short-Term Notes Payable	1,999,497	2,530,453	29
30	Accrued Salaries Payable	594,920	594,920	30
31	Accrued Taxes Payable (excluding real estate taxes)	344,910	344,910	31
32	Accrued Real Estate Taxes(Sch.IX-B)		518,986	32
33	Accrued Interest Payable	12,405	80,161	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,209,816	1,209,816	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,538,965	$ 8,656,663	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,544,901	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	4,820,513	6,656,784	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,820,513	$ 26,201,685	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,359,478	$ 34,858,348	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,728,116)	$ (3,381,155)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,631,362	$ 31,477,193	48

*(See instructions.)

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (7,917,580)	1
2	Restatements (describe):		2
3	**Depreciation**	(103,201)	3
4	**Other Income; Housekeeping Service**	381,695	4
5	**R&M; Interest Expense**	(48,996)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (7,688,082)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,959,966	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,959,966	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)**	$ (5,728,116)	24 *

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

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 15,345,583	1
2	Discounts and Allowances for all Levels	295,075	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,640,658	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,522,772	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,522,772	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	964	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	126,515	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,397	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 131,876	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,834	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,834	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	3,807,048	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,807,048	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 21,129,188	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,776,896	31
32	Health Care	7,099,675	32
33	General Administration	4,522,819	33
	B. Capital Expense		
34	Ownership	2,640,546	34
	C. Ancillary Expense		
35	Special Cost Centers	1,589,734	35
36	Provider Participation Fee	539,552	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 19,169,222	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,959,966	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,959,966	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,789,895	44
45	Private Pay - Net Inpatient Revenue	512,664	45
46	Medicare - Net Inpatient Revenue	3,282,953	46
47	Other-(specify) Hospice	485,955	47
48	Other-(specify) Insurance, Veterans	569,191	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,640,658	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 The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1,934	2,080	$ 114,415	$ 55.01	1
2	Assistant Director of Nursing	1,147	1,233	49,873	40.45	2
3	Registered Nurses	20,665	22,220	830,179	37.36	3
4	Licensed Practical Nurses	63,221	67,979	2,242,290	32.99	4
5	CNAs & Orderlies	133,106	143,125	2,458,626	17.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,078	7,611	177,837	23.37	8
9	Activity Director	2,273	2,445	57,816	23.65	9
10	Activity Assistants	6,437	6,921	105,209	15.20	10
11	Social Service Workers	10,487	11,276	256,621	22.76	11
12	Dietician					12
13	Food Service Supervisor	3,981	4,281	97,330	22.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	37,490	40,312	652,219	16.18	15
16	Dishwashers					16
17	Maintenance Workers	4,504	4,843	105,644	21.81	17
18	Housekeepers	15,933	17,132	322,192	18.81	18
19	Laundry					19
20	Administrator	2,694	2,897	350,446	120.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,990	11,817	230,204	19.48	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	3,756	4,039	76,357	18.90	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,293	2,465	39,719	16.11	33
34	TOTAL (lines 1 - 33)	327,989	352,676	$ 8,166,977 *	$ 23.16	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	965	$ 47,300	01-03	35
36	Medical Director	127	63,250	09-03	36
37	Medical Records Consultant	Monthly	1,200	10-03	37
38	Nurse Consultant	863	64,725	10-03	38
39	Pharmacist Consultant	2,543	27,975	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	70	4,039	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,120	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	MDS Consultant	87	17,400	10-03	47
48					48
49	TOTAL (lines 35 - 48)	4,675	$ 227,009		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	8	312	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8	$ 312		53

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shannon Jones	Administrator	0	$ 150,446
Nathan Davis	Administrative	0	200,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 350,446

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
Marcum LLP	Accounting	$ 52,998
Cray, Kaiser LTD	Accounting	7,300
Personnel Planners	Unemployment Tax Consultant	1,749
MTS Consulting	Unemployment Tax Consultant	1,704
Mosaic	Bookkeeping Fees	155,000
Platinum Billing Solutions	Bookkeeping Fees	282,887
YCC Consulting	Management Consultant	6,200
Maven Health Partners	Insurance Consultant	11,645
Creative Technoloty Solutions	IT Consultant	50,304
Ability Network	Revenue Cycle Mgmt	12,434
See Attached	Legal	74,331
See Supplemental Schedule		91,640
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 748,192

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 154,609
Unemployment Compensation Insurance	44,455
FICA Taxes	577,081
Employee Health Insurance	241,178
Employee Meals	8,205
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	3,985
Employee Benefits	46,743
Employee Pension/Union	65,500
Safe Harbor Match Expense	56,255
Holiday Expense	516
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,198,527

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,310
Health Care Worker Background Check	
(Indicate # of checks performed 165)	1,816
Patient Background Checks	
Dues & Subscriptions	2,194
Licenses & Fees	2,667
See Supplemental Schedule	1,322
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,309

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,379
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,379

**See instructions.

Facility Name & ID Number The Mosaic of Lakeshore # 0050765 Report Period Beginning: 01/01/20 Ending: 12/31/20

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? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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. $ **42,131** 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. $ **539,552**
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. $ **8,205** 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 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.