

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: <u>0050765</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Lake Shore Healthcare & Rehabilitation Centre, Llc</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> 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.	
Address: <u>7200 North Sheridan Road</u> <u>Chicago</u> <u>60626</u>			
NumberCityZip Code			
County: <u>Cook</u>			
Telephone Number: <u>(773)973-7200</u> Fax # <u>(773)338-9373</u>			
HFS ID Number: <u>271503238001</u>		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>01/01/10</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code <u> </u> ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other <u> </u>			

☐ GOVERNMENTAL☐ State☐ County☐ Other

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc

0050765 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>313</u>	Skilled (SNF)	<u>313</u>	<u>114,558</u>	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	<u>313</u>	TOTALS	<u>313</u>	<u>114,558</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>55,459</u>	<u>2,698</u>	<u>15,166</u>	<u>73,323</u>	8
9	SNF/PED					9
10	ICF	<u>14,629</u>		<u>373</u>	<u>15,002</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>70,088</u>	<u>2,698</u>	<u>15,539</u>	<u>88,325</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.10%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

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

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 1/1/2010 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 313 and days of care provided 10,964

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	411,230	67,790	47,023	526,043		526,043	64	526,107		1
2	Food Purchase		523,316		523,316	(42,163)	481,153	(2,259)	478,894		2
3	Housekeeping	18,903	63,944	365,054	447,901		447,901	3,461	451,362		3
4	Laundry	13,570	3,989	243,369	260,928		260,928		260,928		4
5	Heat and Other Utilities			296,513	296,513		296,513	(6,981)	289,532		5
6	Maintenance	128,247	38,832	135,988	303,067		303,067	18,549	321,616		6
7	Other (specify):*										7
8	TOTAL General Services	571,950	697,871	1,087,947	2,357,768	(42,163)	2,315,605	12,834	2,328,439		8
	B. Health Care and Programs										
9	Medical Director			65,700	65,700		65,700	12,987	78,687		9
10	Nursing and Medical Records	4,732,354	375,015	49,786	5,157,155		5,157,155	(78,662)	5,078,493		10
10a	Therapy	320,171		24,953	345,124		345,124		345,124		10a
11	Activities	171,188	35,048	3,762	209,998		209,998		209,998		11
12	Social Services	311,586			311,586		311,586		311,586		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,535,299	410,063	144,201	6,089,563		6,089,563	(65,675)	6,023,888		16
	C. General Administration										
17	Administrative	213,411		433,200	646,611		646,611	(131,691)	514,920		17
18	Directors Fees										18
19	Professional Services			419,171	419,171		419,171	(310,629)	108,542		19
20	Dues, Fees, Subscriptions & Promotions			203,369	203,369		203,369	(98,618)	104,751		20
21	Clerical & General Office Expenses	258,753	38,586	950,888	1,248,227		1,248,227	(657,462)	590,765		21
22	Employee Benefits & Payroll Taxes			1,189,343	1,189,343	42,163	1,231,506		1,231,506		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,464	11,464		11,464	(69)	11,395		24
25	Other Admin. Staff Transportation			38,994	38,994		38,994	(37,259)	1,735		25
26	Insurance-Prop.Liab.Malpractice			173,198	173,198		173,198	15,930	189,128		26
27	Other (specify):*							85,932	85,932		27
28	TOTAL General Administration	472,164	38,586	3,419,627	3,930,377	42,163	3,972,540	(1,133,866)	2,838,674		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,579,413	1,146,520	4,651,775	12,377,708		12,377,708	(1,186,707)	11,191,001		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			523,669	523,669		523,669	82,857	606,526			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			122,095	122,095		122,095	1,204,762	1,326,857			32
33	Real Estate Taxes							398,801	398,801			33
34	Rent-Facility & Grounds			1,918,000	1,918,000		1,918,000	(1,918,000)				34
35	Rent-Equipment & Vehicles							765	765			35
36	Other (specify):*											36
37	TOTAL Ownership			2,563,764	2,563,764		2,563,764	(230,815)	2,332,949			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		429,731	1,401,621	1,831,352		1,831,352		1,831,352			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			641,310	641,310		641,310		641,310			42
43	Other (specify):*	261,618		350,470	612,088		612,088	(612,088)				43
44	TOTAL Special Cost Centers	261,618	429,731	2,393,401	3,084,750		3,084,750	(612,088)	2,472,662			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,841,031	1,576,251	9,608,940	18,026,222		18,026,222	(2,029,610)	15,996,612			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(9,657)	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	(103,278)	30		9
10	Interest and Other Investment Income	(10)	32		10
11	Discounts, Allowances, Rebates & Refunds	(668)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(159)	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	(621)	21		18
19	Entertainment	(449)	21		19
20	Contributions	(12,075)	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	(855,969)	21		24
25	Fund Raising, Advertising and Promotional	(91,141)	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	(831,962)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,905,989)		\$	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)	(123,621)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (123,621)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,029,610)		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

	ID#	0050765
Report Period Beginning:		01/01/12
Ending:		12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Veterans Expenses	\$ (78,610)	10	1
2	Bank Charges	(6,599)	21	2
3	Marketing Salaries	(261,618)	43	3
4	Theft & Loss	(520)	21	4
5	Vending Income	(2,100)	02	5
6	Marketing Consultant	(111,670)	43	6
7	Building Company Amortization	(67,437)	31	7
8	Building Company Office Supplies	(33)	21	8
9	Building Company Bank Charges	(199)	21	9
10	Building Company Professional Fees	(3,000)	19	10
11	Additional R&M	12,111	06	11
12	Capitalized R&M	(14,525)	06	12
13	Collections Expense	(753)	21	13
14	Non-Allowable Seminar	(837)	24	14
15	Non-Allowable Legal	(11,687)	19	15
16	Prior Year Interest	(95)	32	16
17	Prior Year Maintenance	(2,424)	06	17
18	Non-Allowable Management Fees	(238,800)	43	18
19	Voting Income	(150)	21	19
20	Jury Duty Income	(52)	10	20
21	Out of State/Marketing Travel	(37,652)	25	21
22	Collections Expense	(5,312)	21	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	(831,962)		49

ID#

0050765

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

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
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
30	Depreciation	(103,278)	136,320	43,508		6,307							82,85730
31	Amortization of Pre-Op. & Org.	(67,437)	67,437										31
32	Interest	(105)	1,195,463	962		8,442							1,204,76232
33	Real Estate Taxes		391,713			7,088							398,80133
34	Rent-Facility & Grounds		(1,918,000)	27,569		(27,569)							(1,918,000)34
35	Rent-Equipment & Vehicles			765									76535
36	Other (specify):*												36
37	TOTAL Ownership	(170,820)	(127,067)	72,804		(5,732)							(230,815)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):*	(612,088)											(612,088)43
44	TOTAL Special Cost Centers	(612,088)											(612,088)44
45	GRAND TOTAL COST												
	(sum of lines 29, 37 & 44)	(1,905,989)	(108,313)	349,752	(359,566)	(5,494)							(2,029,610)45

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.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,918,000	LSH Property LLC	100.00%	\$	(1,918,000)	1
2	V	26	Insurance Expense		LSH Property LLC	100.00%	15,522	15,522	2
3	V	32	Interest	286	LSH Property LLC	100.00%	1,195,749	1,195,463	3
4	V	30	Depreciation Expense		LSH Property LLC	100.00%	136,320	136,320	4
5	V	31	Amortization Expense		LSH Property LLC	100.00%	67,437	67,437	5
6	V	33	Real Estate Tax Expense		LSH Property LLC	100.00%	391,713	391,713	6
7	V	19	Legal & Professional		LSH Property LLC	100.00%	3,000	3,000	7
8	V	21	Office Supplies & Expenses		LSH Property LLC	100.00%	33	33	8
9	V	21	Bank Charges		LSH Property LLC	100.00%	199	199	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,918,286			\$ 1,809,973	\$ * (108,313)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	MANAGCARE, INC.	100.00%	\$ 64	\$	64
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	3,461		3,461
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	2,676		2,676
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	23,387		23,387
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	12,987		12,987
20	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	229,509		229,509
21	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%			
22	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	4,598		4,598
23	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	213,245		213,245
24	V	24	SEMINARS		MANAGCARE, INC.	100.00%	768		768
25	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	393		393
26	V	26	INSURANCE		MANAGCARE, INC.	100.00%	408		408
27	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	85,932		85,932
28	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	43,508		43,508
29	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	962		962
30	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	27,569		27,569
31	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	765		765
32	V								
33	V	19	BOOKKEEPING FEES	300,480	MANAGCARE, INC.	100.00%			(300,480)
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 300,480			\$ 650,232	\$ *	349,752

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	1,300	1,300	16
17	V	21	OTHER EXPENSES		TETRAD MANAGEMENT, LLC	100.00%	334	334	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	17	MANAGEMENT FEES	361,200	TETRAD MANAGEMENT, LLC			(361,200)	27
28	V								28
29	V								29
30	V		This company is only for Lake Shore Healthcare, therefore there is no applicable page 8						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			\$ 361,200			\$ 1,634	\$ * (359,566)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	\$	4600 TOUHY, LLC	100.00%	\$	\$	15
16	V	5	UTILITIES		4600 TOUHY, LLC				16
17	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC				17
18	V	17	ADMIN.-M. WOLF		4600 TOUHY, LLC				18
19	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC		238	238	19
20	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC				20
21	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC				21
22	V	26	INSURANCE		4600 TOUHY, LLC				22
23	V	30	DEPRECIATION		4600 TOUHY, LLC		6,307	6,307	23
24	V	32	INTEREST EXPENSE		4600 TOUHY, LLC		8,442	8,442	24
25	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC		7,088	7,088	25
26	V								26
27	V								27
28	V								28
29	V	34	RENT	27,569	4600 TOUHY, LLC			(27,569)	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			\$ 27,569			\$ 22,075	\$ * (5,494)	39

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ESTATE CARE OPERATOR, LLC	50.000%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	LSH PROPERTY, LLC		BUILDING CO.	1
2	LAKE SHORE YD DELTA, LLC	50.000%	MAYFIELD CARE CENTER, INC.	CHICAGO	TETRAD MANAGEMENT, LLC		MANAGEMENT CO	2
3			MID AMERICA CARE CENTER, L.L.C.	CHICAGO	4600 TOUHY LLC		BUILDING CO.	3
4					MANAGCARE, INC.		MANAGEMENT CO	4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

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

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Nesanel Davis	Relative	Administrative	0.00%	See Attached	13.96	29.08%	Alloc Salary	\$ 55,586	17-7	1
2	Moshe Davis	Relative	Administrative	0.00%	See Attached	13.96	31.72%	Alloc Salary	56,064	17-7	2
3											3
4											4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by the										7
8	IL Dept. of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 111,650		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	DIETARY	PATIENT DAYS	278,486	4	\$ 201	\$	88,325	\$ 64	1
2	3	HOUSEKEEPING	PATIENT DAYS	278,486	4	10,914		88,325	3,461	2
3	5	UTILITIES	PATIENT DAYS	278,486	4	8,439		88,325	2,676	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	278,486	4	73,740		88,325	23,387	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	278,486	4	40,948		88,325	12,987	5
6	17	ADMINISTRATIVE	PATIENT DAYS	278,486	4	723,635	723,635	88,325	229,509	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	278,486	4			88,325		7
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	278,486	4	14,497		88,325	4,598	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	278,486	4	672,355	453,150	88,325	213,245	9
10	24	SEMINARS	PATIENT DAYS	278,486	4	2,422		88,325	768	10
11	25	ADMIN. STAFF TRANS.	PATIENT DAYS	278,486	4	1,240		88,325	393	11
12	26	INSURANCE	PATIENT DAYS	278,486	4	1,286		88,325	408	12
13	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	278,486	4	270,942		88,325	85,932	13
14	30	DEPRECIATION	PATIENT DAYS	278,486	4	137,181		88,325	43,508	14
15	32	INTEREST EXPENSE	PATIENT DAYS	278,486	4	3,032		88,325	962	15
16	34	RENT - BUILDING (RELATED)	PATIENT DAYS	278,486	4	86,925		88,325	27,569	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	278,486	4	2,412		88,325	765	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,050,169	\$ 1,176,785		\$ 650,232	25

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	3	HOUSEKEEPING	MNGCR. PATIENT DAYS	278,486	4	\$	\$	88,325	\$	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	278,486	4			88,325		2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	278,486	4			88,325		3
4	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	278,486	4			88,325		4
5	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	278,486	4	750		88,325	238	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	278,486	4			88,325		6
7	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	278,486	4			88,325		7
8	26	INSURANCE	MNGCR. PATIENT DAYS	278,486	4			88,325		8
9	30	DEPRECIATION	MNGCR. PATIENT DAYS	278,486	4	19,887		88,325	6,307	9
10	31	INTEREST EXPENSE	MNGCR. PATIENT DAYS	278,486	4	26,618		88,325	8,442	10
11	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	278,486	4	22,347		88,325	7,088	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					\$ 69,602	\$		\$ 22,075	25

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

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

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

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

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

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

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

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

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

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

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

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Private Bank		X	Mortgage- Purchase of Facility			\$	16,677,375			\$	1,124,796	1
2	Capex		X					1,254,835				70,952	2
3	Private Bank		X					2,000,000		6.0000		122,000	3
4	Loan to Members	X						4,900,000					4
5	See Supplemental Schedule												5
	Working Capital												
6	Shareholder Loan		X	Line of Credit				750,000					6
7	Allocated From Managcare		X									962	7
8	See Supplemental Schedule											8,442	8
9	TOTAL Facility Related						\$	25,582,210			\$	1,327,152	9
	B. Non-Facility Related*												
10	Bldg. Co. Interest Income		X									(286)	10
11	Non-Allowable Interest		X										11
12													12
13	See Supplemental Schedule											(10)	13
14	TOTAL Non-Facility Related						\$				\$	(296)	14
15	TOTALS (line 9+line14)						\$	25,582,210			\$	1,326,856	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8	Allocated from 4600 Touhy						\$	\$			\$ 8,442	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital										8,442	14							
	B. Non-Facility Related*																		
15	Cigna Interest Income		X				\$	\$			\$ (10)	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related										(10)	20							

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

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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	391,100	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.)				\$	388,948	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(2,152)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	400,953	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	398,801	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2007	352,949	8	FOR BHF USE ONLY	
		2008	356,490	9		
		2009	367,458	10		
		2010	383,455	11		
		2011	381,860	12		
2012 Accrual= \$381,860 x 1.05 = \$400,953					13	FROM R. E. TAX STATEMENT FOR 2011 \$ 13
Allocation from 4600 Touhy LLC: \$7,088					14	PLUS APPEAL COST FROM LINE 5 \$ 14
					15	LESS REFUND FROM LINE 6 \$ 15
					16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-29-320-035-0000</u>	<u>Long Term Care Property</u>	\$ <u>23,662.81</u>	\$ <u>23,662.81</u>
2. <u>11-29-320-036-0000</u>	<u>Long Term Care Property</u>	\$ <u>83,506.61</u>	\$ <u>83,506.61</u>
3. <u>11-29-320-037-0000</u>	<u>Long Term Care Property</u>	\$ <u>83,843.84</u>	\$ <u>83,843.84</u>
4. <u>11-29-320-038-0000</u>	<u>Long Term Care Property</u>	\$ <u>83,843.84</u>	\$ <u>83,843.84</u>
5. <u>11-29-320-039-0000</u>	<u>Long Term Care Property</u>	\$ <u>83,710.47</u>	\$ <u>83,710.47</u>
6. <u>11-29-320-040-0000</u>	<u>Long Term Care Property</u>	\$ <u>23,292.20</u>	\$ <u>23,292.20</u>
7. <u>See Attached</u>	<u>Allocated from 4600 Touhy LLC</u>	\$ <u>44,694.09</u>	\$ <u>7,087.62</u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
	TOTALS	\$ <u>426,553.86</u>	\$ <u>388,947.39</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0050765

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

☒

(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?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(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

☒

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2010	\$ 1,220,975	1
2	Allocated From 4600 Touhy LLC			19,030	2
3	TOTALS			\$ 1,240,005	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	313		2010	1972	\$ 5,316,218	\$ 136,320	39	\$ 136,313	\$ (7)	\$ 401,579	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		389,897	18,215		11,874	(6,341)	11,874	68
69	Financial Statement Depreciation			523,669			(523,669)		69
70	TOTAL (lines 4 thru 69)		\$ 5,706,115	\$ 678,204		\$ 148,187	\$ (530,017)	\$ 413,453	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Centre, Llc

0050765

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,706,115	\$ 678,204		\$ 148,187	\$ (530,017)	\$ 413,453	1
2	Asphalt, Tile Paving, Curbs, Walls, Sidewalk, Railings, Fence	2010	181,254		20	12,084	12,084	36,251	2
3	24 Color Cameras	2010	10,000		20	1,429	1,429	4,167	3
4	Cameras	2010	5,000		20	714	714	2,024	4
5	Repiping	2010	7,600		20	760	760	2,027	5
6	Stone Decking	2010	9,250		20	617	617	1,542	6
7	Asphalt Repairs	2010	12,450		20	830	830	2,075	7
8	Boiler	2010	12,800		20	2,560	2,560	6,827	8
9	Bumper Guards, Signage	2010	5,282		20	1,056	1,056	2,289	9
10	Reception Cabinetry With Granite Top	2010	7,500		20	375	375	844	10
11	Exterior Signage, Awning	2010	17,320		20	866	866	1,804	11
12	Elevator Controller	2010	59,711		20	2,986	2,986	6,966	12
13	Elevator Repair- Pump/Starter/Wiring	2010	4,500		20	225	225	675	13
14	Electrical Service To West Elevator	2011	4,200		20	420	420	735	14
15	New Doors- Econocare	2011	5,171		20	517	517	819	15
16	Custom Baseboard Covers	2011	5,706		20	1,141	1,141	1,617	16
17	Custom Baseboard Covers	2011	8,929		20	1,786	1,786	2,381	17
18	Generator Toggle Switch	2011	2,501		20	500	500	709	18
19	Waterproofing Membrane And Drain North Patio	2011	11,150		20	743	743	929	19
20	Telephone System	2011	27,000		20	2,700	2,700	4,725	20
21	Elevator Motor Starter & Maxton Valve	2011	5,500		20	275	275	390	21
22	Flooring For Shower Room	2011	6,400		20	640	640	693	22
23	Foorling For Shower Room	2011	5,650		20	565	565	612	23
24	Econocare - Blinds, Wallcovering, Vinyl Flooring	2011	87,478		20	17,496	17,496	27,701	24
25	Activity Room - Wall, Ceiling, Light Fixtures	2011	4,603		20	230	230	460	25
26	Dons & Book Office - Chairs, Filling Cabinet, File Pedastal Tables	2011	6,992		20	350	350	699	26
27	1St Flr Nurse Station - Furniture & Fixture	2011	12,470		20	623	623	1,247	27
28	Tub Room #3 & 4 - Bathroom Wall, Tile, Sink, & Fixtures	2011	13,914		20	696	696	1,391	28
29	Therapy Bathroom - Bathroom Wall, Tile, Sink, & Fixtures	2011	5,908		20	295	295	591	29
30	Therapy Room - Walls,Tile, Millwork, Wallcovering Cabinets	2011	63,094		20	3,155	3,155	6,309	30
31	Therapy & Speech Office - Carpet, Millwork, Wallcovering, Custo	2011	6,835		20	342	342	684	31
32	Repaint Bathroom Doors	2011	2,600		20	130	130	260	32
33	4Th Floor Exit Door Magnetic Locks	2012	4,746		20	791	791	791	33
34	TOTAL (lines 1 thru 33)		\$ 6,329,628	\$ 678,204		\$ 206,083	\$ (472,121)	\$ 534,685	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,329,628	\$ 678,204		\$ 206,083	\$ (472,121)	\$ 534,685	1
2	2Nd Floor Staircase Exit Door Locks	2012	5,721		20	572	572	572	2
3	Sprinkler System Heads And Pipe Fittings	2012	19,153		20	958	958	958	3
4	Epoxy Quartz Surface And Durock On 2Nd And 4Th Floor Showe	2012	3,200		20	320	320	320	4
5	Baseboard Covers	2012	3,547		20	355	355	355	5
6	Flooring In Resident Rooms	2012	8,551		20	1,140	1,140	1,140	6
7	Hvac - Sas Architects	2012	39,873		20	3,323	3,323	3,323	7
8	Idph Plan Review For Remodeling Project	2012	3,540		20	236	236	236	8
9	Walls, Floors, Cove Base, Carpet, Lighting, Tiling, Carpeting, Sco	2012	715,600		20	35,780	35,780	35,780	9
10	Walls, Flooring, Cove Base, Cornices, Plumbing, Ceiling, Locks	2012	79,588		20	3,979	3,979	3,979	10
11	Cubicle Tracks And Curtains, Cornices, Window Panels, Window	2012	2,643		20	132	132	132	11
12	Work On Doors And Door Jams	2012	2,910		20	146	146	146	12
13	Piping And Shut Off Valve	2012	4,900		20	245	245	245	13
14	Blower Motor And Temperature Control	2012	2,640		20	132	132	132	14
15	Ball Valves, Pipes, Couplings	2012	2,950		20	148	148	148	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)		\$ 7,224,443	\$ 678,204		\$ 253,548	\$ (424,656)	\$ 582,150	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,224,443	\$ 678,204		\$ 253,548	\$ (424,656)	\$ 582,150	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)		\$ 7,224,443	\$ 678,204		\$ 253,548	\$ (424,656)	\$ 582,150	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$7,224,443	\$678,204		\$253,548	\$(424,656)	\$582,150	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)		\$7,224,443	\$678,204		\$253,548	\$(424,656)	\$582,150	34

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From 4600 Touhy LLC	2012	162,849	1,481	30	5,428	3,947	5,428	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Managcare	2012	34,000	11,908	20	1,620	(10,288)	1,620	9
10									10
11	Allocated From 4600 Touhy LLC	2012	193,048	4,826	20	4,826		4,826	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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 (12H & 12I lines 1 thru 33)		\$389,897	\$18,215		\$11,874	\$(6,341)	\$11,874	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,581,472	\$99	\$310,949	\$310,850	10	\$912,844	71
72	Current Year Purchases	397,084	25,157	35,921	10,764	10	35,921	72
73	Fully Depreciated Assets	82,754		21	21	10	82,599	73
74								74
75	TOTALS	\$2,061,309	\$25,256	\$346,891	\$321,635		\$1,031,365	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From Managcare	2012	\$44,392	\$6,345	\$6,088	\$(257)	5	\$30,737	76
77										77
78										78
79										79
80	TOTALS			\$44,392	\$6,345	\$6,088	\$(257)		\$30,737	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$10,570,149	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$709,805	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$606,527	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(103,278)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,644,252	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.

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:
- *

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: \$ 765
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$		\$ 470,919	\$		\$ 470,919	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			171,458			171,458	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			491,427			491,427	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				389,050		389,050	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					267,817	40,681		308,498	13
14	TOTAL			\$		\$ 1,401,621	\$ 429,731		\$ 1,831,352	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 66,617	\$ 349,632	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,667,233	5,667,233	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	279,726	292,380	6
7	Other Prepaid Expenses	7,298	7,298	7
8	Accounts Receivable (owners or related parties)		2,268,538	8
9	Other(specify): See Attached Schedule	21,754	553,281	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,042,628	\$ 9,138,362	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	932,013	932,013	15
16	Equipment, at Historical Cost	2,366,753	2,366,753	16
17	Accumulated Depreciation (book methods)	(1,210,336)	(1,613,610)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	15,497	14,345,476	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,103,927	\$ 22,545,677	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,146,555	\$ 31,684,039	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 976,831	\$ 977,383	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,220	41,220	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	273,775	273,775	30
31	Accrued Taxes Payable (excluding real estate taxes)	347,665	347,665	31
32	Accrued Real Estate Taxes(Sch.IX-B)		400,953	32
33	Accrued Interest Payable	9,667	96,339	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,593,289	3,593,289	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,242,447	\$ 5,730,624	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,750,000	25,582,210	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,750,000	\$ 25,582,210	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,992,447	\$ 31,312,834	46
47	TOTAL EQUITY(page 18, line 24)	\$ 154,108	\$ 371,205	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,146,555	\$ 31,684,039	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (118,217)	1
2	Restatements (describe):		2
3	Late 2011 Journal Entries	(425,848)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (544,065)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	698,173	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)	\$ 698,173	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)	\$ 154,108	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 19,799,337	1
2	Discounts and Allowances for all Levels	(4,357,133)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,442,204	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,686,835	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,686,835	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	457,254	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,628	19
20	Radiology and X-Ray	7,898	20
21	Other Medical Services	88,596	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 592,376	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,970	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,970	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,724,395	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,357,768	31
32	Health Care	6,089,563	32
33	General Administration	3,930,377	33
	B. Capital Expense		
34	Ownership	2,563,764	34
	C. Ancillary Expense		
35	Special Cost Centers	2,443,440	35
36	Provider Participation Fee	641,310	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,026,222	40
41	Income before Income Taxes (line 30 minus line 40)**	698,173	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 698,173	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 10,303,482	44
45	Private Pay - Net Inpatient Revenue	718,379	45
46	Medicare - Net Inpatient Revenue	3,779,658	46
47	Other-(specify) Veterans/Hospice	640,685	47
48	Other-(specify) Prior Period Revenues		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,442,204	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.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,737	1,839	\$ 86,687	\$ 47.14	1
2	Assistant Director of Nursing	1,979	2,141	78,266	36.56	2
3	Registered Nurses	41,597	45,320	1,307,040	28.84	3
4	Licensed Practical Nurses	54,777	57,017	1,348,444	23.65	4
5	CNAs & Orderlies	170,215	182,966	1,868,079	10.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	18,252	20,328	320,171	15.75	8
9	Activity Director	5,933	6,634	93,081	14.03	9
10	Activity Assistants	8,217	8,612	78,107	9.07	10
11	Social Service Workers	18,044	19,081	311,586	16.33	11
12	Dietician					12
13	Food Service Supervisor	3,267	3,544	60,316	17.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,203	34,710	350,914	10.11	15
16	Dishwashers					16
17	Maintenance Workers	7,877	8,415	128,247	15.24	17
18	Housekeepers	1,387	1,701	18,903	11.11	18
19	Laundry	1,086	1,279	13,570	10.61	19
20	Administrator	3,024	3,184	184,464	57.93	20
21	Assistant Administrator	892	952	28,947	30.41	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,841	20,717	258,753	12.49	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	2,237	2,504	43,838	17.51	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,973	5,233	261,617	49.99	33
34	TOTAL (lines 1 - 33)	397,538	426,176	\$ 6,841,030 *	\$ 16.05	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	1,156	\$ 47,023	01-03	35
36	Medical Director	Monthly	65,700	09-03	36
37	Medical Records Consultant	Monthly	1,560	10-03	37
38	Nurse Consultant	30	8,905	10-03	38
39	Pharmacist Consultant	Monthly	13,821	10-03	39
40	Physical Therapy Consultant	Monthly	13,125	10a-03	40
41	Occupational Therapy Consultant	137	10,685	10a-03	41
42	Respiratory Therapy Consultant	17	1,143	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	3,762	11-03	44
45	Social Service Consultant				45
46	Other(specify) Quality Assurance	Monthly	25,500	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,350	\$ 191,224		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

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

Yes

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

IL Council on LTC- \$31,742

(3) Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$70,089

Line10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YESXNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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.

\$641,310

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.

\$42,163

Has any meal income been offset against related costs?

No

Indicate the amount.

\$N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100% Ln 14

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$N/A

(17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

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

Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT