

		FOR BHF USE					

LL1

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

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: 0052183

Facility Name: The Mosaic of Springfield

Address: 555 West Carpenter Springfield 62702
Number City Zip Code

County: Sangamon

Telephone Number: (217) 525-1880 Fax # (217) 525-7762

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2013

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) *
* Subject to the attached Accountants Consulting Report (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number The Mosaic of Springfield

0052183 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	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>251</u>	Skilled (SNF)	<u>251</u>	<u>91,866</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>251</u>	TOTALS	<u>251</u>	<u>91,866</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>44,370</u>	<u>6,185</u>	<u>12,169</u>	<u>62,724</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,370</u>	<u>6,185</u>	<u>12,169</u>	<u>62,724</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.28%

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)
N/A

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 01/01/2013

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 01/01/2013 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 251 and days of care provided 7,808

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number The Mosaic of Springfield # 0052183 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	398,973	80,180	19,866	499,019		499,019	81	499,100			1
2	Food Purchase		332,005		332,005		332,005	(327)	331,678			2
3	Housekeeping		7,992	381,863	389,855		389,855	1,069	390,924			3
4	Laundry		8,177	249,141	257,318		257,318		257,318			4
5	Heat and Other Utilities			319,057	319,057		319,057	(40,881)	278,176			5
6	Maintenance	109,099	31,145	105,952	246,196		246,196	(5,523)	240,673			6
7	Other (specify):*											7
8	TOTAL General Services	508,072	459,499	1,075,879	2,043,450		2,043,450	(45,581)	1,997,869			8
	B. Health Care and Programs											
9	Medical Director			46,981	46,981		46,981		46,981			9
10	Nursing and Medical Records	3,709,515	222,728	282,287	4,214,530		4,214,530	29,173	4,243,703			10
10a	Therapy	64,299		325	64,624		64,624		64,624			10a
11	Activities	292,922	8,330	75	301,327		301,327		301,327			11
12	Social Services	242,513			242,513		242,513	7,095	249,608			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							16,222	16,222			15
16	TOTAL Health Care and Programs	4,309,249	231,058	329,668	4,869,975		4,869,975	52,491	4,922,466			16
	C. General Administration											
17	Administrative	176,210		214,805	391,015		391,015	(140,173)	250,842			17
18	Directors Fees											18
19	Professional Services			480,057	480,057		480,057	(324,256)	155,801			19
20	Dues, Fees, Subscriptions & Promotions			106,672	106,672		106,672	(54,993)	51,679			20
21	Clerical & General Office Expenses	268,054	44,947	1,895,714	2,208,715		2,208,715	(1,552,722)	655,993			21
22	Employee Benefits & Payroll Taxes			877,519	877,519		877,519		877,519			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,867	1,867		1,867	1,204	3,071			24
25	Other Admin. Staff Transportation			18,704	18,704		18,704	5,411	24,115			25
26	Insurance-Prop.Liab.Malpractice			131,112	131,112		131,112	1,167	132,279			26
27	Other (specify):*							55,838	55,838			27
28	TOTAL General Administration	444,264	44,947	3,726,450	4,215,661		4,215,661	(2,008,524)	2,207,137			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,261,585	735,504	5,131,997	11,129,086		11,129,086	(2,001,614)	9,127,472			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.

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			147,720	147,720		147,720	431,967	579,687			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							3,536	3,536			32
33	Real Estate Taxes			101,289	101,289		101,289	6,036	107,325			33
34	Rent-Facility & Grounds			1,164,300	1,164,300		1,164,300	(1,161,496)	2,804			34
35	Rent-Equipment & Vehicles			22,122	22,122		22,122	(10,402)	11,720			35
36	Other (specify):*											36
37	TOTAL Ownership			1,435,431	1,435,431		1,435,431	(730,359)	705,072			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		533,427	1,643,477	2,176,904		2,176,904		2,176,904			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			444,251	444,251		444,251		444,251			42
43	Other (specify):*	15,320		45,180	60,500		60,500	(60,500)	0			43
44	TOTAL Special Cost Centers	15,320	533,427	2,132,908	2,681,655		2,681,655	(60,500)	2,621,155			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,276,905	1,268,931	8,700,336	15,246,172		15,246,172	(2,792,473)	12,453,699			45

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

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	(43,148)	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	428,880	30		9
10	Interest and Other Investment Income	(2,100)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(327)	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	(69,586)	21		18
19	Entertainment				19
20	Contributions	(200)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,592,866)	21		24
25	Fund Raising, Advertising and Promotional	(47,319)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,558,965)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,885,631)		\$	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)	93,158		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 93,158		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,792,473)		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

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	Gateshead Media	\$ (81)	21	1
2	Medical Records	(1,017)	10	2
3	Miscellaneous Income	(2,052)	21	3
4	Gain/Loss on Sale	(22)	06	4
5	Marketing Expense	(45,180)	43	5
6	Bank Charges	(9,694)	21	6
7	Marketing Salaries	(15,320)	43	7
8	Theft and Loss	(417)	21	8
9	Sequestration	(47,755)	21	9
10	Non-Allowable Auto Expense	(11,064)	35	10
11	Non-Allowable Expense	(1,000)	21	11
12	Capitalized R&M	(11,924)	06	12
13	Additional R&M	2,645	06	13
14	Non-Allowable Legal	(28,951)	19	14
15	PAC Dues	(8,026)	20	15
16	Rent for Sale Leaseback Arrangment	(1,164,300)	34	16
17	Non-Allowable Expense	(214,805)	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	(1,558,965)		49

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Mosaic of Springfield # 0052183 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			81									81	1
2	Food Purchase	(327)											(327)	2
3	Housekeeping			1,069									1,069	3
4	Laundry													4
5	Heat and Other Utilities	(43,148)		1,876	391								(40,881)	5
6	Maintenance	(9,301)		2,360	1,043	375							(5,523)	6
7	Other (specify):*													7
8	TOTAL General Services	(52,776)		5,386	1,434	375							(45,581)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,017)		30,190									29,173	10
10a	Therapy													10a
11	Activities													11
12	Social Services			7,095									7,095	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			16,222									16,222	15
16	TOTAL Health Care and Programs	(1,017)		53,508									52,491	16
	C. General Administration													
17	Administrative	(214,805)		74,632									(140,173)	17
18	Directors Fees													18
19	Professional Services	(28,951)		(116,577)	149	(178,878)							(324,256)	19
20	Fees, Subscriptions & Promotions	(55,545)		514	38								(54,993)	20
21	Clerical & General Office Expenses	(1,723,453)		85,061	27	85,642							(1,552,722)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			244		961							1,204	24
25	Other Admin. Staff Transportation			727		4,684							5,411	25
26	Insurance-Prop.Liab.Malpractice			590	252	325							1,167	26
27	Other (specify):*			41,456		14,382							55,838	27
28	TOTAL General Administration	(2,022,754)		86,647	466	(72,884)							(2,008,524)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(2,076,546)		145,541	1,900	(72,509)							(2,001,614)	29

Summary B

12/31/16

[illegible]

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

X 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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

Facility Name & ID Number	The Mosaic of Springfield	#	0052183	Report Period Beginning:	01/01/16	Ending:	12/31/16
--------------------------------------	----------------------------------	----------	----------------	---------------------------------	-----------------	----------------	-----------------

VII. RELATED PARTIES (continued)

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

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

1		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	\$	MOSAIC HEALTHCARE	100.00%	\$ 81	\$ 81	15
16	V	3	HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	1,069	1,069	16
17	V	5	UTILITIES		MOSAIC HEALTHCARE	100.00%	1,876	1,876	17
18	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	2,360	2,360	18
19	V	10	NURSING SALARIES		MOSAIC HEALTHCARE	100.00%	75,370	75,370	19
20	V	12	SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	7,095	7,095	20
21	V	15	NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	16,222	16,222	21
22	V	17	ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	74,632	74,632	22
23	V	19	PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	2,311	2,311	23
24	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	514	514	24
25	V	21	CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE	100.00%	136,107	136,107	25
26	V	21	CLERICAL AND GENERAL EXP		MOSAIC HEALTHCARE	100.00%	16,724	16,724	26
27	V	24	SEMINARS		MOSAIC HEALTHCARE	100.00%	244	244	27
28	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	727	727	28
29	V	26	INSURANCE		MOSAIC HEALTHCARE	100.00%	590	590	29
30	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	41,456	41,456	30
31	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	20,349	20,349	31
32	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	663	663	32
33	V	19	BOOKKEEPING/MANAGED CARE	73,708	MOSAIC HEALTHCARE	100.00%		(73,708)	33
34	V	19	ADMINISTRATIVE	45,180	MOSAIC HEALTHCARE	100.00%		(45,180)	34
35	V	10	MDS CONSULTANT	45,180	MOSAIC HEALTHCARE	100.00%		(45,180)	35
36	V	21	OFFICE CONSULTANT	67,770	MOSAIC HEALTHCARE	100.00%		(67,770)	36
37	V								37
38	V								38
39	Total			\$ 231,838			\$ 398,391	\$ * 166,553	39

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

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	5	UTILITIES		4600 TOUHY, LLC	100.00%	391	\$	391
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	1,043		1,043
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	149		149
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	38		38
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	27		27
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	252		252
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	3,087		3,087
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	5,636		5,636
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	6,036		6,036
24	V								
25	V	34	RENT	20,349	4600 TOUHY, LLC	100.00%			(20,349)
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 20,349			\$ 16,660	\$ *	(3,689)

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

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	6	MAINTENANCE & REPAIR	\$	PLATINUM BILLING SOLUTIONS	30.00%	\$ 375	\$ 375	15
16	V	19	PROFESSIONAL SERVICES		PLATINUM BILLING SOLUTIONS	30.00%	1,981	1,981	16
17	V	21	CLERICAL & GENERAL		PLATINUM BILLING SOLUTIONS	30.00%	13,254	13,254	17
18	V	21	CLERICAL & GENERAL- SALARY		PLATINUM BILLING SOLUTIONS	30.00%	72,388	72,388	18
19	V	24	BUSINESS SEMINAR		PLATINUM BILLING SOLUTIONS	30.00%	961	961	19
20	V	25	AUTO & TRAVEL		PLATINUM BILLING SOLUTIONS	30.00%	4,684	4,684	20
21	V	26	INSURANCE		PLATINUM BILLING SOLUTIONS	30.00%	325	325	21
22	V	27	EMPLOYEE BENEFITS/TAXES		PLATINUM BILLING SOLUTIONS	30.00%	14,382	14,382	22
23	V	34	RENT		PLATINUM BILLING SOLUTIONS	30.00%	2,804	2,804	23
24	V	19	AR MANAGEMENT SERVICES	180,859	PLATINUM BILLING SOLUTIONS	30.00%		(180,859)	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			\$ 180,859			\$ 111,154	\$ * (69,705)	39

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

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.

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.

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.

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.

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.

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.

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, LLC	0.01%	MOSAIC OF BEACON	CHICAGO	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	CENTRAL ILLINOIS OPERATIONS	99.99%	MOSAIC OF LAKE SHORE	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	BOOKKEEPING	2
3			MOSAIC OF UPTOWN	CHICAGO	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	ADMIN. CONSULTANT	3
4			COLONIAL HEALTHCARE & REHABILITATION CTR., LLC	PRINCETON	PLATINUM BILLING SERVICES	LAKEWOOD, NJ	AR MANAGEMENT SERVICE	4
5			THE HEIGHTS HEALTHCARE & REHABILITATION CTR, LLC	PEORIA HEIGHTS	Worthy Insurance Group, LLC	Skokie	Insurance Company	5
6			MORTON TERRACE HEALTHCARE & REHAB CTR., LLC	MORTON				6
7			MORTON VILLA HEALTHCARE & REHABILITATION CTR., LLC	MORTON				7
8			RIVERSHORES NURSING & REHABILITATION CENTER, LLC	MARSEILLES				8
9			MOSAIC OF MAYFIELD	CHICAGO				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 The Mosaic of Springfield # 0052183 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

Facility Name & ID Number	The Mosaic of Springfield
---------------------------	---------------------------

0052183

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

MOSAIC HEALTHCARE

Street Address

4600 W. TOUHY AVENUE, SUITE 200

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(773) 463-1313

Fax Number

(773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	483,176	10	\$ 625	\$	62,724	\$ 81	1
2	3	HOUSEKEEPING	PATIENT DAYS	483,176	10	8,235		62,724	1,069	2
3	5	UTILITIES	PATIENT DAYS	483,176	10	14,454		62,724	1,876	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	483,176	10	18,179		62,724	2,360	4
5	10	NURSING SALARIES	PATIENT DAYS	483,176	10	580,592	580,592	62,724	75,370	5
6	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	483,176	10	54,655	54,655	62,724	7,095	6
7	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	483,176	10	124,964		62,724	16,222	7
8	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	483,176	10	574,906	574,906	62,724	74,632	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	483,176	10	17,800		62,724	2,311	9
10	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	483,176	10	3,962		62,724	514	10
11	21	CLERICAL AND GENERAL SA	PATIENT DAYS	483,176	10	1,048,463	1,048,463	62,724	136,107	11
12	21	CLERICAL AND GENERAL EX	PATIENT DAYS	483,176	10	128,829		62,724	16,724	12
13	24	SEMINARS	PATIENT DAYS	483,176	10	1,876		62,724	244	13
14	25	ADMIN. STAFF TRANS.	PATIENT DAYS	483,176	10	5,603		62,724	727	14
15	26	INSURANCE	PATIENT DAYS	483,176	10	4,543		62,724	590	15
16	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	483,176	10	319,345		62,724	41,456	16
17	34	RENT - BUILDING (RELATED)	PATIENT DAYS	483,176	10	156,750		62,724	20,349	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	483,176	10	5,104		62,724	663	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,068,885	\$ 2,258,616		\$ 398,391	25

Ending: 12/31/16

((773) 463- 5311

Ending: 12/31/16

(773) 463- 5311

Ending: 12/31/16

Facility Name & ID Number	The Mosaic of Springfield
---------------------------	---------------------------

0052183

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number**Fax Number**

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

Facility Name & ID Number	The Mosaic of Springfield
---------------------------	---------------------------

0052183

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number**Fax Number**

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

Ending: 12/31/16

Ending: 12/31/16

Facility Name & ID Number	The Mosaic of Springfield
---------------------------	---------------------------

0052183

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number**Fax Number**

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

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							\$	\$			\$	1	
2												2	
3												3	
4												4	
5					-							5	
	Working Capital												
6	Allocated from 4600 Touhy	X									5,636	6	
7												7	
8					-							8	
9	TOTAL Facility Related						\$	\$			\$ 5,636	9	
	B. Non-Facility Related*												
10	Interest Income		X								(2,100)	10	
11												11	
12												12	
13					-							13	
14	TOTAL Non-Facility Related						\$	\$			\$ (2,100)	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 3,536	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.)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

FACILITY NAME	<u>The Mosaic of Springfield</u>	COUNTY	<u>Sangamon</u>
---------------	----------------------------------	--------	-----------------

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

The Mosaic of Springfield

COUNTY

Sangamon

FACILITY IDPH LICENSE NUMBER

0052183

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	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.

A. Square Feet: 61,806

B. General Construction Type: Exterior Brick Frame Number of Stories 4

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		2013	\$ 895,459	1
2	Allocated from 4600 Touhy LLC			11,683	2
3	TOTALS			\$ 907,142	3

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	251		2013	1975	\$ 7,724,626	\$	35	\$ 220,704	\$ 220,704	\$ 882,816	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

See Page 12A, Line 70 for total

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)		136,100	3,087		5,694	2,607	27,788	68
69	Financial Statement Depreciation			147,720			(147,720)		69
70	TOTAL (lines 4 thru 69)		\$ 7,860,726	\$ 150,807		\$ 226,398	\$ 75,591	\$ 910,604	70

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

Facility Name & ID Number The Mosaic of Springfield

0052183

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	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		\$ 7,860,726	\$ 150,807		\$ 226,398	\$ 75,591	\$ 910,604	1
2	Painting Of South Elevation	2013	7,940		20	794	794	2,845	2
3	Installed 10 New 2 Inch Copper Clad Boiler Tubes	2013	9,375		20	938	938	3,438	3
4	Rebranding Of Signage	2013	4,407		20	220	220	790	4
5	Installed Dome Camera At Dock Door, Installed Delayed Egress S	2013	2,795		20	559	559	1,910	5
6	Water Heater	2013	12,989		20	649	649	2,030	6
7	Fixed Wiring For Nurse Call System	2014	5,286		20	264	264	727	7
8	Installed 17 Emergency Pull Cords & 14 Bed Visual Stations	2014	8,495		20	1,699	1,699	4,531	8
9	Installed 2 Hydraulic Jacks In Elevator	2014	17,425		20	871	871	2,178	9
10	Installed 4 Accutech Door Packs	2014	5,705		20	285	285	666	10
11	Installed Soft Started In #1 Passenger Elevator	2014	2,850		20	143	143	309	11
12	Installed New Water Heater For Entire Building	2014	12,560		20	628	628	1,884	12
13	Installed New Generator For Entire Facility	2014	28,017		20	1,401	1,401	3,385	13
14	Installed New Hvac	2014	2,742		20	137	137	388	14
15	Painted Parking Lot Stripes & Exterior Handrails In Upper & Lo	2014	3,500		20	175	175	452	15
16	Installed New Signage For Exits And Resident Room Numbers	2014	6,614		20	331	331	965	16
17	Installed 1 Traditional Slope Style Awning	2014	3,571		20	179	179	476	17
18	Installed New Fence Around Building	2014	11,390		20	570	570	1,471	18
19	3Rd Floor Resident Room-Paint Walls & Ceiling, Install Cabinets	2014	217,149		20	10,857	10,857	28,048	19
20	3Rd Floor Corridor-Paint Door Frames, Installed Door Guards, F	2014	60,479		20	3,024	3,024	7,812	20
21	Therapy / Dining Rm-Install Sink, Faucet, Countertops, Fixtures,	2014	32,028		20	1,601	1,601	4,137	21
22	3Rd Floor Bathrooms-Installed Vanity Tops, Toilet Doors, Floorin	2014	168,834		20	8,442	8,442	21,808	22
23	Supervision & Moblization Storage For 3Rd Floor Renovation	2014	55,750		20	2,788	2,788	7,201	23
24	Install Handles On Corridor Doors, Vanity Lights, Light Fixtures	2014	67,437		20	3,372	3,372	8,711	24
25	Resident Rms 320, 322, 327, 329 - Install New Bath Tubs	2014	15,600		20	780	780	2,015	25
26	Installed New Cabinets, Countertops, Sink, Faucet, Stove, Therapi	2014	6,955		20	348	348	898	26
27	Replaced 4 Shut Off Valves	2014	2,590		20	130	130	335	27
28	3Rd Floor Restrooms-Paint, Install New Sink, Faucet, Toliet, Mirr	2014	3,708		20	185	185	479	28
29	3Rd Floor Showers - Replace Floor, Plumbing, Fixtures, Shower V	2014	77,510		20	3,876	3,876	10,012	29
30	Paint Doors In 3Rd Floor Corridor	2014	17,873		20	894	894	2,309	30
31	Install Carpet In Main Entrance, Dining, Conference Rm, Admini	2014	51,480		20	2,574	2,574	6,650	31
32	Replace Pressure Backflow Preventer Assembly	2015	7,544		20	377	377	692	32
33	Installation Of Telephone System	2015	17,088		20	1,709	1,709	3,133	33
34	TOTAL (lines 1 thru 33)		\$ 8,808,413	\$ 150,807		\$ 277,196	\$ 126,389	\$ 1,043,285	34

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

Facility Name & ID Number The Mosaic of Springfield

0052183

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,808,413	\$ 150,807		\$ 277,196	\$ 126,389	\$ 1,043,285	1
2	Installed Fire Doors	2015	10,796		20	540	540	855	2
3	Installation Of New Windows For 3Rd Floor Lounge	2015	3,300		20	165	165	248	3
4	Install Commercial Carpet Tiles	2015	4,136		20	207	207	259	4
5	2 Ton Condensing Unit For The Nurses Station	2015	3,181		20	159	159	225	5
6	4 Ptac Air Conditioner	2015	2,925		20	146	146	232	6
7	Paint 3Rd Floor Wing Hallway Walls	2015	4,000		20	200	200	300	7
8	Security System	2016	14,607		20	730	730	730	8
9	Repaired Plumbing Pipes	2016	12,450		20	623	623	623	9
10	Replace Manual Ramp System	2016	2,933		20	147	147	147	10
11	Repaired Wiring For Doors	2016	4,346		20	217	217	217	11
12	Repaired Airphone System Cabling	2016	7,578		20	379	379	379	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)		\$ 8,878,665	\$ 150,807		\$ 280,708	\$ 129,901	\$ 1,047,498	34

**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 12C, Carried Forward		\$ 8,878,665	\$ 150,807		\$ 280,708	\$ 129,901	\$ 1,047,498	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)		\$ 8,878,665	\$ 150,807		\$ 280,708	\$ 129,901	\$ 1,047,498	34

**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		\$ 8,878,665	\$ 150,807		\$ 280,708	\$ 129,901	\$ 1,047,498	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)		\$ 8,878,665	\$ 150,807		\$ 280,708	\$ 129,901	\$ 1,047,498	34

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

Facility Name & ID Number The Mosaic of Springfield

0052183

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									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)		\$	\$		\$	\$	\$	34

**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 12F, Carried Forward		\$	\$		\$	\$	\$	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)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number The Mosaic of Springfield

0052183

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 4600 Touhy LLC	2012	66,655	1,709	30	2,222	513	11,109	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Mosaic HC	2013	1,119		20	56	56	224	9
10	Allocated from Mosaic HC	2012	13,917		20	696	696	3,479	10
11									11
12	Allocated from 4600 Touhy LLC	2012	42,926	1,106	20	2,146	1,040	10,731	12
13	Allocated from 4600 Touhy LLC	2013	10,445	245	20	522	277	2,089	13
14	Allocated from 4600 Touhy LLC	2014	1,038	27	20	52	25	156	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)		\$ 136,100	\$ 3,087		\$ 5,694	\$ 2,607	\$ 27,788	34

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

Facility Name & ID Number The Mosaic of Springfield

0052183

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 136,100	\$ 3,087		\$ 5,694	\$ 2,607	\$ 27,788	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)		\$ 136,100	\$ 3,087		\$ 5,694	\$ 2,607	\$ 27,788	34

**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	\$ 2,843,804	\$	\$ 297,047	\$ 297,047	10	\$ 1,087,561	71
72	Current Year Purchases	19,320		1,932	1,932	10	1,932	72
73	Fully Depreciated Assets	33,339				10	33,339	73
74								74
75	TOTALS	\$ 2,896,463	\$	\$ 298,979	\$ 298,979		\$ 1,122,832	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 HC	2016	\$ 12,332	\$	\$	\$	5	\$ 12,332	76
77										77
78										78
79										79
80	TOTALS			\$ 12,332	\$	\$	\$		\$ 12,332	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)	\$ 12,694,601	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 150,807	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 579,687	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 428,880	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,182,662	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 89,008	92
93			93
94			94
95		\$ 89,008	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: ARC Healthcare II Operating Partnership (Sale Leaseback Arrangement)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		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:		251		\$ 1,164,300			3
4	Additions							4
5					(1,164,300)			5
6	Allocated from Platinum				2,804			6
7	TOTAL		251		\$ 2,804			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: \$ 2,131
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Dodge	\$ 695	\$ 9,590	17
18					18
19					19
20					20
21	TOTAL		\$ 695	\$ 9,590	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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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

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.

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

12345678										
	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	\$		\$ 682,903	\$		\$ 682,903	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			194,094			194,094	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			627,524			627,524	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				494,580		494,580	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					138,956	38,847		177,803	13
14	TOTAL			\$		\$ 1,643,477	\$ 533,427		\$ 2,176,904	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.

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	\$ 26,619	\$	1
2	Cash-Patient Deposits	23,538		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,092,712		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	125,921		6
7	Other Prepaid Expenses	51,712		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	25,907		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,346,409	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,257,209		15
16	Equipment, at Historical Cost	451,871		16
17	Accumulated Depreciation (book methods)	(442,192)		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): <u>See Attached Schedule</u>	898,967		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,165,855	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,512,264	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,361,615	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,538		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	432,347		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,037		31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,725		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	47,756		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,963,018	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	4,879,702		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,879,702	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,842,720	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,330,456)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,512,264	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (216,859)	1
2	Restatements (describe):		2
3	PY Contributions	(711,489)	3
4	PY State Replacement Tax	(9,143)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (937,491)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,104,454)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	711,489	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)	\$ (2,392,965)	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)	\$ (3,330,456)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **The Mosaic of Springfield**

0052183

Report Period Beginning: 01/01/16

Ending: 12/31/16

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	\$ 10,385,184	1
2	Discounts and Allowances for all Levels	(1,300,614)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,084,570	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,667,229	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,667,229	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	372,617	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,253	19
20	Radiology and X-Ray	5,502	20
21	Other Medical Services	275	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 384,647	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,100	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,100	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,172	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,172	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,141,718	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,043,450	31
32	Health Care	4,869,975	32
33	General Administration	4,215,661	33
	B. Capital Expense		
34	Ownership	1,435,431	34
	C. Ancillary Expense		
35	Special Cost Centers	2,237,404	35
36	Provider Participation Fee	444,251	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,246,172	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,104,454)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,104,454)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,322,764	44
45	Private Pay - Net Inpatient Revenue	1,207,850	45
46	Medicare - Net Inpatient Revenue	2,223,428	46
47	Other-(specify) Hospice/Manged Care	1,220,567	47
48	Other-(specify) Insurance	109,961	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,084,570	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	2,030	2,207	\$ 104,637	\$ 47.41	1
2	Assistant Director of Nursing	1,756	1,909	64,885	33.99	2
3	Registered Nurses	15,389	16,727	525,367	31.41	3
4	Licensed Practical Nurses	52,816	57,408	1,501,406	26.15	4
5	CNAs & Orderlies	101,950	110,815	1,471,884	13.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,939	2,108	64,299	30.50	8
9	Activity Director	2,517	2,736	50,130	18.32	9
10	Activity Assistants	21,552	23,426	242,792	10.36	10
11	Social Service Workers	8,181	8,892	163,820	18.42	11
12	Dietician					12
13	Food Service Supervisor	2,076	2,256	36,691	16.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,013	31,536	362,282	11.49	15
16	Dishwashers					16
17	Maintenance Workers	6,363	6,916	109,099	15.77	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,059	2,238	113,844	50.87	20
21	Assistant Administrator	1,794	1,950	62,366	31.98	21
22	Other Administrative					22
23	Office Manager	3,123	3,394	71,983	21.21	23
24	Clerical	16,333	17,754	196,071	11.04	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	2,859	3,108	41,336	13.30	31
32	Other Health Care(specify)					32
33	Other(specify)	6,468	7,029	94,013	13.38	33
34	TOTAL (lines 1 - 33)	278,218	302,409	\$ 5,276,905 *	\$ 17.45	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	Monthly	\$ 19,866	01-03	35
36	Medical Director	Monthly	46,981	09-03	36
37	Medical Records Consultant	Quarterly	1,020	10-03	37
38	Nurse Consultant	Monthly	95,203	10-03	38
39	Pharmacist Consultant	Monthly	1,900	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	5	325	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Per Visit	75	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	5	\$ 165,370		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	402	16,066	10-03	51
52	Certified Nurse Assistants/Aides	6,724	168,098	10-03	52
53	TOTAL (lines 50 - 52)	7,126	\$ 184,164		53

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

** See instructions.

Facility Name & ID Number <u>The Mosaic of Springfield</u>	STATE OF ILLINOIS # <u>0052183</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
---	--	---	--------------------------------

Page 22

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. IL Council on Long Term Care: \$24,322

(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. \$ 40,934 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? Yes
 If YES, give effective date of lease. 12/31/2014

(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. \$ 444,251
 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 benefit on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

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

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

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

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