		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0054536

Facility Name: Beacon Care Center

Address: 4538 N Beacon (Number) Chicago (City) 60640 (Zip Code)

County: Cook

Telephone Number: (773)275-7200 **Fax #** (773)275-7543

HFS ID Number:

Date of Initial License for Current Owners: 04/01/2017

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mendel Schneider **Telephone Number:** (847)933-1274
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 01/01/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) See Accountants report Attached
(Firm Name & Address) Mendel Schneider C.P.A.
4051 Old Orchard rd
(Telephone) (847)933-1274 Fax # (847)933-1283

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 Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	143	Skilled (SNF)	143	52,195	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	143	TOTALS	143	52,195	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,231	2,231	8
9	SNF/PED					9
10	ICF	29,914	106		30,020	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,914	106	2,231	32,251	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.79%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/2017

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/2017 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified 143 and days of care provided 1,952

Medicare Intermediary National Government services

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	310,576	28,594	1,960	341,130		341,130	11,535	352,665			1
2	Food Purchase		225,357		225,357		225,357		225,357			2
3	Housekeeping	172,159	19,247		191,406		191,406		191,406			3
4	Laundry	6,624	13,720	76,001	96,345		96,345		96,345			4
5	Heat and Other Utilities			126,103	126,103		126,103	630	126,733			5
6	Maintenance	118,294	9,913	52,881	181,088		181,088	17,252	198,340			6
7	Other (specify):*											7
8	**TOTAL General Services**	607,653	296,831	256,945	1,161,429		1,161,429	29,417	1,190,846			8
	B. Health Care and Programs											
9	Medical Director			9,200	9,200		9,200		9,200			9
10	Nursing and Medical Records	2,268,129	126,396	98,598	2,493,123		2,493,123	4,114	2,497,237			10
10a	Therapy											10a
11	Activities	108,380	10,271		118,651		118,651		118,651			11
12	Social Services	73,240		1,426	74,666		74,666		74,666			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,449,749	136,667	109,224	2,695,640		2,695,640	4,114	2,699,754			16
	C. General Administration											
17	Administrative	92,945		324,989	417,934		417,934	(324,989)	92,945			17
18	Directors Fees											18
19	Professional Services			47,408	47,408		47,408	168,049	215,457			19
20	Dues, Fees, Subscriptions & Promotions			18,799	18,799		18,799	(7,205)	11,594			20
21	Clerical & General Office Expenses	227,479	26,841	262,672	516,992		516,992	81,808	598,800			21
22	Employee Benefits & Payroll Taxes			507,422	507,422		507,422		507,422			22
23	Inservice Training & Education											23
24	Travel and Seminar			239	239		239		239			24
25	Other Admin. Staff Transportation							3,660	3,660			25
26	Insurance-Prop.Liab.Malpractice			272,754	272,754		272,754	792	273,546			26
27	Other (specify):* **Allocated benifets**							34,624	34,624			27
28	**TOTAL General Administration**	320,424	26,841	1,434,283	1,781,548		1,781,548	(43,261)	1,738,287			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,377,826	460,339	1,800,452	5,638,617		5,638,617	(9,730)	5,628,887			29

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

Facility Name & ID Number Beacon Care Center #0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			3,545	3,545		3,545	(61)	3,484			30
31	Amortization of Pre-Op. & Org.			9,830	9,830		9,830		9,830			31
32	Interest			79,600	79,600		79,600	(5,770)	73,830			32
33	Real Estate Taxes			243,885	243,885		243,885		243,885			33
34	Rent-Facility & Grounds			1,266,385	1,266,385		1,266,385	18,339	1,284,724			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,603,245	1,603,245		1,603,245	12,508	1,615,753			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,104	528,352	636,456		636,456		636,456			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			269,588	269,588		269,588		269,588			42
43	Other (specify):* **Bad Debt**			65,025	65,025		65,025	(65,025)				43
44	**TOTAL Special Cost Centers**		108,104	862,965	971,069		971,069	(65,025)	906,044			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,377,826	568,443	4,266,662	8,212,931		8,212,931	(62,247)	8,150,684			45

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

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(61)	30		9
10	Interest and Other Investment Income	(5,770)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,274)	21		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	(36,785)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(65,025)	43		24
25	Fund Raising, Advertising and Promotional	(7,205)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (117,120)		$	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)	54,873		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 54,873		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (62,247)		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

Beacon Care Center

ID# 0054536

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	11,535	0	0	0	0	0	0	0	0	0	11,535	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	630	0	0	0	0	0	0	0	0	0	630	5
6	Maintenance	0	17,252	0	0	0	0	0	0	0	0	0	17,252	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	29,417	0	0	0	0	0	0	0	0	0	29,417	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	4,114	0	0	0	0	0	0	0	0	0	4,114	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	4,114	0	0	0	0	0	0	0	0	0	4,114	16
	C. General Administration													
17	Administrative	0	(324,989)	0	0	0	0	0	0	0	0	0	(324,989)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	168,049	0	0	0	0	0	0	0	0	0	168,049	19
20	Fees, Subscriptions & Promotions	(7,205)	0	0	0	0	0	0	0	0	0	0	(7,205)	20
21	Clerical & General Office Expenses	(39,059)	120,867	0	0	0	0	0	0	0	0	0	81,808	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	3,660	0	0	0	0	0	0	0	0	0	3,660	25
26	Insurance-Prop.Liab.Malpractice	0	792	0	0	0	0	0	0	0	0	0	792	26
27	Other (specify):*	0	34,624	0	0	0	0	0	0	0	0	0	34,624	27
28	**TOTAL General Administration**	(46,264)	3,003	0	0	0	0	0	0	0	0	0	(43,261)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(46,264)	36,534	0	0	0	0	0	0	0	0	0	(9,730)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(61)	0	0	0	0	0	0	0	0	0	0	(61)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,770)	0	0	0	0	0	0	0	0	0	0	(5,770)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	18,339	0	0	0	0	0	0	0	0	0	18,339	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(5,831)	18,339	0	0	0	0	0	0	0	0	0	12,508	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(65,025)	0	0	0	0	0	0	0	0	0	0	(65,025)	43
44	**TOTAL Special Cost Centers**	(65,025)	0	0	0	0	0	0	0	0	0	0	(65,025)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(117,120)	54,873	0	0	0	0	0	0	0	0	0	(62,247)	45

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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
Bert Heineman	47.5	Uptown Care Center LLC	Chicago	Everest Care Group	Skokie	Management
Moshe Levovitz	47.5	Mayfield Care Center LLC	Chicago	Everest Chicago MT L	Skokie	Master Tenant
Henry Heineman	1.5					
David Openheimer	1					
Yeruchom Levovitz	1					
Yisroel levovitz	.5					
Zev meisels	1					

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 324,989	Everest care Group	100.00%	$	$ (324,989)	1
2	V	5	Utilities		Everest care Group		630	630	2
3	V	6	Maintenance Salaries		Everest care Group		17,252	17,252	3
4	V	10	Nursing Salaries		Everest care Group		4,114	4,114	4
5	V	1	Dietary Wages		Everest care Group		11,535	11,535	5
6	V	21	Clerical Wages		Everest care Group		96,892	96,892	6
7	V	19	Professional fees		Everest care Group		168,049	168,049	7
8	V	21	Office		Everest care Group		23,975	23,975	8
9	V	34	Rent		Everest care Group		18,339	18,339	9
10	V	26	Insurance		Everest care Group		792	792	10
11	V	27	Allocated Benifets		Everest care Group		34,624	34,624	11
12	V	25	Auto		Everest care Group		3,660	3,660	12
13	V								13
14	Total			$ 324,989			$ 379,862	$ * 54,873	14

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

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											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 Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Everest Care Group
Street Address: 5215 Old Orchard Road Suite 960
City / State / Zip Code: Skokie, Il 60077
Phone Number: (773) 945-1000
Fax Number: (773) 751-2027

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Number of beds	609	3	$ 2,685	$	143	$ 630	1
2	6	Maintenance Salaries	Number of beds	609	3	73,471	73,471	143	17,252	2
3	10	Nursing Salries	Number of beds	609	3	17,519	17,519	143	4,114	3
4	1	Dietary Salaries	Number of beds	609	3	49,123	49,123	143	11,535	4
5	21	Clerical Salaries	Number of beds	609	3	412,636	412,636	143	96,892	5
6	19	Professional fees	Number of beds	609	3	715,678		143	168,049	6
7	21	Office Supplies	Number of beds	609	3	102,102		143	23,975	7
8	34	Rent	Number of beds	609	3	78,100		143	18,339	8
9	26	Insurance	Number of beds	609	3	3,374		143	792	9
10	27	Allocated benifets	Number of beds	609	3	147,455		143	34,624	10
11	25	Auto Expense	Number of beds	609	3	15,588		143	3,660	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					$ 1,617,731	$ 552,749		$ 379,862	25

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	Congressional Bank		X	Working Capital				2,995,201			79,600	6
7												7
8												8
9	TOTAL Facility Related						$	$ 2,995,201			$ 79,600	9
	B. Non-Facility Related*											
10	Interest Income										(5,770)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,770)	14
15	TOTALS (line 9+line14)						$	$ 2,995,201			$ 73,830	15

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

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

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

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	252,980	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.)	$	243,556	2
3. Under or (over) accrual (line 2 minus line 1).	$	(9,424)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	253,309	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.	$	243,885	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013		8
2014		9
2015		10
2016	226,491	11
2017	243,556	12

243556 x 1.04

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beacon Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054536

CONTACT PERSON REGARDING THIS REPORT Mendel Schneider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

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

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-115-017-0000	Long Term Care Facility	$ 96,756.24	$ 96,756.24
2.	14-17-115-018-0000	Long Term Care Facility	$ 92,567.75	$ 92,567.75
3.	14-17-115-030-0000	Long Term Care Facility	$ 54,231.77	$ 54,231.77
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 243,555.76	$ 243,555.76

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 X NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: Brick B. General Construction Type: Exterior _____ Frame Brick Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 29,491 2. Number of Years Over Which it is Being Amortized: 3

3. Current Period Amortization: 9,830 4. Dates Incurred: 04/01/2017

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wander Guard System			2017	5,478	274	20	274		548	9
10	Fill, Inlet Louvers, Ball valve,Sprinkler Heads on Cooling Tower			2017	2,789	139	20	139		278	10
11	Sign, Awning for building			2017	7,573	379	20	379		758	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 15,840	$ 792		$ 792	$	$ 1,584	70

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

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$	$	$	$		$	71
72	Current Year Purchases	18,843	2,753	2,692	(61)	7	2,692	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 18,843	$ 2,753	$ 2,692	$ (61)		$ 2,692	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 34,683	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 3,545	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 3,484	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (61)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,276	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Everest chicago MT LLC

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. [X] 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:		143	04/01/2017	$ 1,266,385			3
4	Additions							4
5	Allocated from Everest Care Group				18,339			5
6								6
7	TOTAL		143		$ 1,284,724 **			7

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

9. Option to Buy: [ ] YES [ ] NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

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

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(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

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

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

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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	39-3	hrs	$		$ 182,294	$		$ 182,294	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			131,748			131,748	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			214,310			214,310	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				98,586		98,586	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Radiology,lab	39-2					9,518		9,518	12
13	Other (specify):									13
14	TOTAL			$		$ 528,352	$ 108,104		$ 636,456	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.

STATE OF ILLINOIS

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 24,940	$	1
2	Cash-Patient Deposits	31,239		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,432,668		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,583		6
7	Other Prepaid Expenses	11,319		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from related Parties	156,437		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,767,186	$	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	15,840		15
16	Equipment, at Historical Cost	18,843		16
17	Accumulated Depreciation (book methods)	(4,322)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	29,491		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(17,203)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 42,649	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,809,835	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,481,013	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,782		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,950		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,566		31
32	Accrued Real Estate Taxes(Sch.IX-B)	253,309		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related parties	2,995,201		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,854,821	$	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,854,821	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,044,986)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,809,835	$	48

*(See instructions.)

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,328,484)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,328,484)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,716,502)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,716,502)	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)**	$ (3,044,986)	24 *

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

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,490,659	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,490,659	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,770	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,770	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,496,429	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,161,429	31
32	Health Care	2,695,640	32
33	General Administration	1,781,548	33
	B. Capital Expense		
34	Ownership	1,603,245	34
	C. Ancillary Expense		
35	Special Cost Centers	701,481	35
36	Provider Participation Fee	269,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,212,931	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,716,502)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,716,502)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,046,661	44
45	Private Pay - Net Inpatient Revenue	22,468	45
46	Medicare - Net Inpatient Revenue	1,096,268	46
47	Other-(specify) Insurance	106,969	47
48	Other-(specify) Med B	218,293	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,490,659	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No, Cash basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,152	1,196	$ 86,385	$ 72.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,615	14,180	589,034	41.54	3
4	Licensed Practical Nurses	25,707	29,439	833,872	28.33	4
5	CNAs & Orderlies	43,281	52,161	714,157	13.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,040	40,032	19.62	9
10	Activity Assistants	5,446	5,678	68,348	12.04	10
11	Social Service Workers	2,218	2,425	73,240	30.20	11
12	Dietician					12
13	Food Service Supervisor	3,859	4,197	80,152	19.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,900	18,749	230,424	12.29	15
16	Dishwashers					16
17	Maintenance Workers	5,843	6,402	118,294	18.48	17
18	Housekeepers	12,489	13,586	172,159	12.67	18
19	Laundry	482	521	6,624	12.71	19
20	Administrator	1,760	1,840	92,945	50.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,911	12,395	227,479	18.35	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	2,150	2,310	44,681	19.34	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,813	167,119	$ 3,377,826 *	$ 20.21	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	33	$ 1,960	1-3	35
36	Medical Director	Monthly	9,200	9-3	36
37	Medical Records Consultant	20	800	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,885	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	28	1,426	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	81	$ 17,271		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	240	4,200	10-3	52
53	TOTAL (lines 50 - 52)	240	$ 4,200		53

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Orlando Arjona	Administrative		$ 65,000
Josh Graber	Administrative		27,945
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,945

B. Administrative - Other

Description	Amount
Everest Care Group, LLC	$ 324,989
TOTAL (agree to Schedule V, line 17, col. 3)	$ 324,989
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Achieve Accreditation	Accreditation	$ 11,405
Marcum LLP	Accounting	9,013
Compliance Consulting	Consulting	9,350
LCG Advisors	Financial Consulting	3,723
Personnel Planners	UC Consulting	711
Stout Risous Ross	Financial Consulting	5,000
Carden Tracy & Stolberg	Legal	2,667
Congressional Bank	Loc Legal	3,884
Neal Gerber & Eisenberg	Legal	1,655
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 47,408

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,616
Unemployment Compensation Insurance	55,374
FICA Taxes	258,404
Employee Health Insurance	135,028
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 507,422

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,370
(Indicate # of checks performed 137)	
Patient Background Checks 70	705
City of Chicago	400
Illinois Council	5,720
Joint commission	4,640
Misc Licenses	3,974
Less: Public Relations Expense	( )
Non-allowable advertising	(7,205)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,594

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Illinois council on LTC	239
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 239

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Beacon Care Center # 0054536 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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. **Illinois council on LTC $5720**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(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?

(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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,572** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **269,588**
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. $ **0** Has any meal income been offset against related costs? **N/A** 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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No**
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:

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees