

		FOR BHF USE				

LL1

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

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.

<p>I. IDPH License ID Number: <u>0054544</u></p> <p>Facility Name: <u>Uptown Care Center, Llc</u></p> <p>Address: <u>4920 N. Kenmore Ave</u> <u>Chicago</u> <u>60640</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773)769-2700</u> Fax # <u>(773)769-3226</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>04/1/2017</u></p> <p>Type of Ownership:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; vertical-align: top;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mendel Schneider</u> Telephone Number: <u>(847)933-1274</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p align="center">I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2018</u> to <u>12/31/2018</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) _____ (Title) _____ (Signed) _____ (Date) _____ </td> </tr> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;"> (Print Name and Title) <u>See Accountants report Attached</u> (Firm Name & Address) <u>Mendel S. Schneider C.P.A. & Associates</u> <u>4051 Old Orchard Rd, Skokie, IL 60076</u> (Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u> </td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____ (Signed) _____ (Date) _____	Paid Preparer	(Print Name and Title) <u>See Accountants report Attached</u> (Firm Name & Address) <u>Mendel S. Schneider C.P.A. & Associates</u> <u>4051 Old Orchard Rd, Skokie, IL 60076</u> (Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____ (Signed) _____ (Date) _____							
Paid Preparer	(Print Name and Title) <u>See Accountants report Attached</u> (Firm Name & Address) <u>Mendel S. Schneider C.P.A. & Associates</u> <u>4051 Old Orchard Rd, Skokie, IL 60076</u> (Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u>							

Facility Name & ID Number Uptown Care Center, Llc

0054544 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	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	310	Skilled (SNF)	310	113,150	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	310	TOTALS	310	113,150	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			6,676	6,676	8
9	SNF/PED					9
10	ICF	86,617	1,556		88,173	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	86,617	1,556	6,676	94,849	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.83%

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

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 04/01/2017

J. Was the facility purchased or leased after January 1, 1978?
YES 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 310 and days of care provided 6,360

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 Fiscal Year: 12/31

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

Facility Name & ID Number Uptown Care Center, Llc # 0054544 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 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	498,728	92,981		591,709		591,709	25,005	616,714		1
2	Food Purchase		582,269		582,269		582,269		582,269		2
3	Housekeeping	436,282	49,764		486,046		486,046		486,046		3
4	Laundry	51,580	17,657	239,898	309,135		309,135		309,135		4
5	Heat and Other Utilities			278,268	278,268		278,268	1,367	279,635		5
6	Maintenance	145,215	18,750	110,947	274,912		274,912	37,399	312,311		6
7	Other (specify):*										7
8	TOTAL General Services	1,131,805	761,421	629,113	2,522,339		2,522,339	63,771	2,586,110		8
	B. Health Care and Programs										
9	Medical Director			19,500	19,500		19,500		19,500		9
10	Nursing and Medical Records	5,412,117	256,974	38,003	5,707,094		5,707,094	8,918	5,716,012		10
10a	Therapy										10a
11	Activities	218,134	11,371		229,505		229,505		229,505		11
12	Social Services	198,895		310	199,205		199,205		199,205		12
13	CNA Training										13
14	Program Transportation			20,927	20,927		20,927		20,927		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,829,146	268,345	78,740	6,176,231		6,176,231	8,918	6,185,149		16
	C. General Administration										
17	Administrative	133,517		909,837	1,043,354		1,043,354	(909,837)	133,517		17
18	Directors Fees										18
19	Professional Services			50,818	50,818		50,818	364,302	415,120		19
20	Dues, Fees, Subscriptions & Promotions			53,816	53,816		53,816	(31,510)	22,306		20
21	Clerical & General Office Expenses	594,262	64,374	484,676	1,143,312		1,143,312	185,154	1,328,466		21
22	Employee Benefits & Payroll Taxes			1,230,736	1,230,736		1,230,736		1,230,736		22
23	Inservice Training & Education										23
24	Travel and Seminar			140	140		140		140		24
25	Other Admin. Staff Transportation							7,935	7,935		25
26	Insurance-Prop.Liab.Malpractice			579,546	579,546		579,546	1,717	581,263		26
27	Other (specify):* Allocated benifets							75,059	75,059		27
28	TOTAL General Administration	727,779	64,374	3,309,569	4,101,722		4,101,722	(307,180)	3,794,542		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,688,730	1,094,140	4,017,422	12,800,292		12,800,292	(234,491)	12,565,801		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			20,130	20,130		20,130	(2,154)	17,976		30
31	Amortization of Pre-Op. & Org.			21,311	21,311		21,311		21,311		31
32	Interest			186,081	186,081		186,081	(22,430)	163,651		32
33	Real Estate Taxes			479,210	479,210		479,210		479,210		33
34	Rent-Facility & Grounds			2,859,713	2,859,713		2,859,713	39,755	2,899,468		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			3,566,445	3,566,445		3,566,445	15,171	3,581,616		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		450,729	945,709	1,396,438		1,396,438		1,396,438		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			704,169	704,169		704,169		704,169		42
43	Other (specify):* Bad Debt			181,931	181,931		181,931	(181,931)			43
44	TOTAL Special Cost Centers		450,729	1,831,809	2,282,538		2,282,538	(181,931)	2,100,607		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,688,730	1,544,869	9,415,676	18,649,275		18,649,275	(401,251)	18,248,024		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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(2,154)	30		9
10	Interest and Other Investment Income	(22,430)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,596)	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	(70,268)	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	(181,931)	43		24
25	Fund Raising, Advertising and Promotional	(31,510)	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)	\$ (314,889)		\$	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	2	
		Amount	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)	(86,362)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (86,362)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (401,251)		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	2	3	4	
		Yes	No	Amount	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

Uptown Care Center, Llc

ID# 0054544

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
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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 Uptown Care Center, Llc# 0054544

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	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	0	25,005	0	0	0	0	0	0	0	0	0	25,005	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	1,367	0	0	0	0	0	0	0	0	0	1,367	5
6	Maintenance	0	37,399	0	0	0	0	0	0	0	0	0	37,399	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	63,771	0	0	0	0	0	0	0	0	0	63,771	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	8,918	0	0	0	0	0	0	0	0	0	8,918	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	8,918	0	0	0	0	0	0	0	0	0	8,918	16
	C. General Administration													
17	Administrative	0	(909,837)	0	0	0	0	0	0	0	0	0	(909,837)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	364,302	0	0	0	0	0	0	0	0	0	364,302	19
20	Fees, Subscriptions & Promotions	(31,510)	0	0	0	0	0	0	0	0	0	0	(31,510)	20
21	Clerical & General Office Expenses	(76,864)	262,018	0	0	0	0	0	0	0	0	0	185,154	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	7,935	0	0	0	0	0	0	0	0	0	7,935	25
26	Insurance-Prop.Liab.Malpractice	0	1,717	0	0	0	0	0	0	0	0	0	1,717	26
27	Other (specify):*	0	75,059	0	0	0	0	0	0	0	0	0	75,059	27
28	TOTAL General Administration	(108,374)	(198,806)	0	0	0	0	0	0	0	0	0	(307,180)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(108,374)	(126,117)	0	0	0	0	0	0	0	0	0	(234,491)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Uptown Care Center, Llc

0054544

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(2,154)	0	0	0	0	0	0	0	0	0	0	(2,154) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(22,430)	0	0	0	0	0	0	0	0	0	0	(22,430) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	39,755	0	0	0	0	0	0	0	0	0	39,755 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	(24,584)	39,755	0	0	0	0	0	0	0	0	0	15,171 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):*	(181,931)	0	0	0	0	0	0	0	0	0	0	(181,931) 43
44	TOTAL Special Cost Centers	(181,931)	0	0	0	0	0	0	0	0	0	0	(181,931) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(314,889)	(86,362)	0	0	0	0	0	0	0	0	0	(401,251) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bert Heineman	47.5	Mayfield Care Center LLC	Chicago	Everest Care Group	Skokie	Management
Moshe Levovitz	47.5	Beacon Care Center	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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fees	\$ 909,837	Everest Care Group	100.00%	\$	\$ (909,837)	1
2	V	5 Utilities		Everest Care Group		1,367	1,367	2
3	V	6 Maintenance Salaries		Everest Care Group		37,399	37,399	3
4	V	10 Nursing Salaries		Everest Care Group		8,918	8,918	4
5	V	1 Dietary Wages		Everest Care Group		25,005	25,005	5
6	V	21 Clerical Wages		Everest Care Group		210,045	210,045	6
7	V	19 Professional fees		Everest Care Group		364,302	364,302	7
8	V	21 Office		Everest Care Group		51,973	51,973	8
9	V	34 Rent		Everest Care Group		39,755	39,755	9
10	V	26 Insurance		Everest Care Group		1,717	1,717	10
11	V	27 Allocated Benifets		Everest Care Group		75,059	75,059	11
12	V	25 Auto		Everest Care Group		7,935	7,935	12
13	V							13
14	Total		\$ 909,837			\$ 823,475	\$ * (86,362)	14

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

Facility Name & ID Number

Uptown Care Center, Llc

0054544

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 Uptown Care Center, Llc # 0054544 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 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									\$		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 Uptown Care Center, Llc

0054544

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 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 Rd Ste 960
 City / State / Zip Code Skokie, IL 60077
 Phone Number (773)945-1000
 Fax Number (773)751-2027

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Number Of beds	609	3	\$ 2,685	\$ 310	\$ 1,367	1
2	6	Maintenance Wages	Number Of beds	609	3	73,471	73,471	37,399	2
3	10	Nursing Wages	Number Of beds	609	3	17,519	17,519	8,918	3
4	1	Dietary Wages	Number Of beds	609	3	49,123	49,123	25,005	4
5	21	Clerical Wages	Number Of beds	609	3	412,636	412,636	210,045	5
6	19	Professional Fees	Number Of beds	609	3	715,678	310	364,302	6
7	21	Office Supplies	Number Of beds	609	3	102,102	310	51,973	7
8	34	Rent	Number Of beds	609	3	78,100	310	39,755	8
9	26	Insurance	Number Of beds	609	3	3,374	310	1,717	9
10	27	Allocated Benifets	Number Of beds	609	3	147,455	310	75,059	10
11	25	Auto Expense	Number Of beds	609	3	15,588	310	7,935	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	\$ 823,475	25

Facility Name & ID Number

Uptown Care Center, Llc

0054544

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
Working Capital																
6	Congressional bank		X	Working Capital				3,285,707			186,081					
7																
8																
9	TOTAL Facility Related						\$	\$ 3,285,707			\$ 186,081					
B. Non-Facility Related*																
10	Interest Income										(22,430)					
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$ (22,430)					
15	TOTALS (line 9+line14)						\$	\$ 3,285,707			\$ 163,651					

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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.		\$	469,074	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.)		\$	467,135	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,939)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	481,149	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.		\$	479,210	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	_____	8	
	2014	_____	9	
	2015	_____	10	
	2016	448,556	11	
	2017	467,135	12	
467135 X 1.03				

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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Uptown Care Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054544

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-08-410-018-000</u>	<u>Nursing Home</u>	\$ <u>128,071.97</u>	\$ <u>128,071.97</u>
2. <u>14-08-410-019-0000</u>	<u>Nursing Home</u>	\$ <u>128,071.97</u>	\$ <u>128,071.97</u>
3. <u>14-08-410-020-0000</u>	<u>Nursing Home</u>	\$ <u>128,071.97</u>	\$ <u>128,071.97</u>
4. <u>14-08-410-021-0000</u>	<u>Nursing Home</u>	\$ <u>82,919.52</u>	\$ <u>82,919.52</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>467,135.43</u></u>	\$ <u><u>467,135.43</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 Uptown Care Center, Llc

0054544

Report Period Beginning:

01/01/2018 Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 94,500 B. General Construction Type: Exterior Frame Number of Stories

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

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

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: 63,932 2. Number of Years Over Which it is Being Amortized: 3

3. Current Period Amortization: 21,311 4. Dates Incurred: 04/01/17

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Uptown Care Center, Llc

0054544

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	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					\$	\$		\$	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9		Fire Alarm Systems	2017		9,050	453	20	453		906
10		Aluminum Signs	2017		5,709	285	20	285		570
11		Awning	2017		4,124	206	20	206		412
12		Door System	2017		2,852	143	20	143		286
13		Dialysis room Plumbing Repairs	2017		5,000	250	20	250		500
14		Awning	2018		3,124	208	15	208		208
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 29,859	\$ 1,545		\$ 1,545	\$	\$ 2,882	70

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

Facility Name & ID Number Uptown Care Center, Llc

0054544

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	\$ 20,361	\$ 2,036	\$ 2,036	\$	10	\$ 4,072	71
72	Current Year Purchases	49,724	7,126	4,972	(2,154)	10	4,972	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 70,085	\$ 9,162	\$ 7,008	\$ (2,154)		\$ 9,044	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	Resident Transportation	Van	2018	\$ 87,954	\$ 9,423	\$ 9,423	\$	7	\$ 9,423	76
77										77
78										78
79										79
80	TOTALS			\$ 87,954	\$ 9,423	\$ 9,423	\$		\$ 9,423	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)	\$ 187,898	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,130	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,976	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,154)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 21,349	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 Uptown Care Center, Llc

0054544

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. 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:		310	04/01/2018	\$ 2,859,713			3
4	Additions							4
5	Allocated from Everest care Group				39,755			5
6								6
7	TOTAL		310		\$ 2,899,468			7

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	\$ _____

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: \$ _____ 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	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	\$		\$ 339,668	\$		\$ 339,668	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			119,086			119,086	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			486,955			486,955	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				326,922		326,922	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs				123,807		123,807	11
12	Other (specify): <u>Dialysis</u>									12
13	Other (specify): _____									13
14	TOTAL			\$		\$ 945,709	\$ 450,729		\$ 1,396,438	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.

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 648,299	\$	1
2	Cash-Patient Deposits	75,119		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,251,412		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	212,630		6
7	Other Prepaid Expenses	68,321		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related parties	91,571		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,347,352	\$	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	29,859		15
16	Equipment, at Historical Cost	158,039		16
17	Accumulated Depreciation (book methods)	(23,538)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	63,932		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(37,294)		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)	\$ 190,998	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,538,350	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,628,980	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	77,544		28
29	Short-Term Notes Payable	3,285,707		29
30	Accrued Salaries Payable	210,300		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,320		31
32	Accrued Real Estate Taxes(Sch.IX-B)	481,149		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,703,000	\$	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)	\$ 6,703,000	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,164,650)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,538,350	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (808,917)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (808,917)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(355,733)	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)	\$ (355,733)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,164,650)	24 *

* This must agree with page 17, line 47.

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	\$ 18,271,112	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 18,271,112	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***	22,430	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,430	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)	\$ 18,293,542	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,522,339	31
32	Health Care	6,176,231	32
33	General Administration	4,101,722	33
B. Capital Expense			
34	Ownership	3,566,445	34
C. Ancillary Expense			
35	Special Cost Centers	1,578,369	35
36	Provider Participation Fee	704,169	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,649,275	40
41	Income before Income Taxes (line 30 minus line 40)**	(355,733)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (355,733)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 13,883,440	44
45	Private Pay - Net Inpatient Revenue	341,103	45
46	Medicare - Net Inpatient Revenue	3,577,449	46
47	Other-(specify) <u>Insurance</u>	124,376	47
48	Other-(specify) <u>Med B</u>	344,744	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 18,271,112	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Uptown Care Center, Llc

0054544

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

12/31/2018

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	2,032	2,080	\$ 120,404	\$ 57.89	1
2	Assistant Director of Nursing	840	1,092	70,096	64.19	2
3	Registered Nurses	40,559	44,319	1,467,395	33.11	3
4	Licensed Practical Nurses	49,620	54,848	1,644,902	29.99	4
5	CNAs & Orderlies	131,352	143,067	2,057,902	14.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,834	2,080	43,043	20.69	9
10	Activity Assistants	12,653	14,306	175,091	12.24	10
11	Social Service Workers	9,712	10,957	198,895	18.15	11
12	Dietician					12
13	Food Service Supervisor	3,485	4,080	134,623	33.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,875	27,212	364,105	13.38	15
16	Dishwashers					16
17	Maintenance Workers	7,414	8,783	145,215	16.53	17
18	Housekeepers	28,168	31,816	436,282	13.71	18
19	Laundry	2,945	3,448	51,580	14.96	19
20	Administrator	2,216	2,280	133,517	58.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,744	22,080	594,262	26.91	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	2,016	2,279	51,418	22.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	341,465	374,727	\$ 7,688,730 *	\$ 20.52	34

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

** See instructions.

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			35
36	Medical Director	monthly 19,500	9-3	36
37	Medical Records Consultant	monthly 1,200	10-3	37
38	Nurse Consultant	monthly 20,125	10-3	38
39	Pharmacist Consultant	monthly 16,678	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	7 310	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	7 \$ 57,813		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Aaron Gruman	Administrator		\$ 133,517	Workers' Compensation Insurance	\$ 116,986	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	32,259	Advertising: Employee Recruitment	6,384		
				FICA Taxes	588,188	Health Care Worker Background Check			
				Employee Health Insurance	493,303	(Indicate # of checks performed <u>269</u>)	2,690		
				Employee Meals		Patient Background Checks	845		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	31,510		
						Misc Licenses	2,786		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 133,517						
B. Administrative - Other									
Description			Amount						
Everest care group Management fees			\$ 909,837			Less: Public Relations Expense	()		
						Non-allowable advertising	(31,510)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 909,837	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,230,736	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 22,306		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
KattenMuchinRosenman	Legal		\$ 7,657				Out-of-State Travel	\$	
Breslin, Young & Slaughter	Legal		764						
Carden Tracy & Stolberg	Legal		4,700				In-State Travel		
James Quail	Legal		814						
Neal, Gerber & Eisenberg LLP	Legal		3,587				Seminar Expense		
Personel Planners	UC Tax Consultant		1,713				Ill council on ltc	140	
Marcum	Accounting		4,378						
Achieve	Accreditation		11,400				Entertainment Expense	()	
Compliance Consulting	Consultant		7,734				(agree to Sch. V, line 24, col. 8)		
LCG advisors	Financial consulting		8,071				TOTAL	\$ 140	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 50,818	TOTAL		\$			

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Uptown Care Center, Llc# 0054544Report Period Beginning: 01/01/2018Ending: 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? No
If YES, give association name and amount. _____
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,827 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. \$ 704,169
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. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
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. \$ _____
- (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. Yes
Attach invoices and a summary of services for all architect and appraisal fees