

Facility Name & ID Number Mayfield Care Center

0054528 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	156	Skilled (SNF)	156	56,940	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	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			5,956	5,956	8
9	SNF/PED					9
10	ICF	43,957	224		44,181	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,957	224	5,956	50,137	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.05%

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 104 and days of care provided 5,575

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: _____ Fiscal Year: _____

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

Facility Name & ID Number Mayfield Care Center # 0054528 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	350,335	55,625		405,960		405,960	12,583	418,543		1
2	Food Purchase		321,473		321,473		321,473		321,473		2
3	Housekeeping	246,116	34,197		280,313		280,313		280,313		3
4	Laundry	88,169	10,667	34,801	133,637		133,637		133,637		4
5	Heat and Other Utilities			159,225	159,225		159,225	688	159,913		5
6	Maintenance	64,561	15,484	74,998	155,043		155,043	18,820	173,863		6
7	Other (specify):*										7
8	TOTAL General Services	749,181	437,446	269,024	1,455,651		1,455,651	32,091	1,487,742		8
	B. Health Care and Programs										
9	Medical Director			11,500	11,500		11,500		11,500		9
10	Nursing and Medical Records	3,140,577	228,156	10,593	3,379,326		3,379,326	4,488	3,383,814		10
10a	Therapy										10a
11	Activities	156,296	6,811		163,107		163,107		163,107		11
12	Social Services	99,637		806	100,443		100,443		100,443		12
13	CNA Training										13
14	Program Transportation			16,978	16,978		16,978		16,978		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,396,510	234,967	39,877	3,671,354		3,671,354	4,488	3,675,842		16
	C. General Administration										
17	Administrative	170,159		534,674	704,833		704,833	(534,674)	170,159		17
18	Directors Fees										18
19	Professional Services			39,923	39,923		39,923	183,326	223,249		19
20	Dues, Fees, Subscriptions & Promotions			30,861	30,861		30,861	(18,063)	12,798		20
21	Clerical & General Office Expenses	441,396	32,247	313,950	787,593		787,593	58,533	846,126		21
22	Employee Benefits & Payroll Taxes			795,616	795,616		795,616		795,616		22
23	Inservice Training & Education										23
24	Travel and Seminar			320	320		320		320		24
25	Other Admin. Staff Transportation							3,993	3,993		25
26	Insurance-Prop.Liab.Malpractice			300,720	300,720		300,720	864	301,584		26
27	Other (specify):* Allocated Benifets							37,772	37,772		27
28	TOTAL General Administration	611,555	32,247	2,016,064	2,659,866		2,659,866	(268,249)	2,391,617		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,757,246	704,660	2,324,965	7,786,871		7,786,871	(231,670)	7,555,201		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			24,013	24,013		24,013	(6,322)	17,691		30
31	Amortization of Pre-Op. & Org.			10,724	10,724		10,724		10,724		31
32	Interest			103,953	103,953		103,953	(206)	103,747		32
33	Real Estate Taxes			220,062	220,062		220,062		220,062		33
34	Rent-Facility & Grounds			1,496,157	1,496,157		1,496,157	20,006	1,516,163		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			1,854,909	1,854,909		1,854,909	13,478	1,868,387		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		199,053	701,386	900,439		900,439		900,439		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			349,565	349,565		349,565		349,565		42
43	Other (specify):* Bad debt Expense			106,957	106,957		106,957	(106,957)			43
44	TOTAL Special Cost Centers		199,053	1,157,908	1,356,961		1,356,961	(106,957)	1,250,004		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,757,246	903,713	5,337,782	10,998,741		10,998,741	(325,149)	10,673,592		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	(6,322)	30		9
10	Interest and Other Investment Income	(206)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,238)	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	(69,083)	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	(106,957)	43		24
25	Fund Raising, Advertising and Promotional	(18,063)	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)	\$ (204,869)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(120,280)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (120,280)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (325,149)		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

Mayfield Care Center

ID# 0054528

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 Mayfield Care Center# 0054528

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	12,583	0	0	0	0	0	0	0	0	0	12,583	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	688	0	0	0	0	0	0	0	0	0	688	5
6	Maintenance	0	18,820	0	0	0	0	0	0	0	0	0	18,820	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	32,091	0	0	0	0	0	0	0	0	0	32,091	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	4,488	0	0	0	0	0	0	0	0	0	4,488	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	4,488	0	0	0	0	0	0	0	0	0	4,488	16
	C. General Administration													
17	Administrative	0	(534,674)	0	0	0	0	0	0	0	0	0	(534,674)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	183,326	0	0	0	0	0	0	0	0	0	183,326	19
20	Fees, Subscriptions & Promotions	(18,063)	0	0	0	0	0	0	0	0	0	0	(18,063)	20
21	Clerical & General Office Expenses	(73,321)	131,854	0	0	0	0	0	0	0	0	0	58,533	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	3,993	0	0	0	0	0	0	0	0	0	3,993	25
26	Insurance-Prop.Liab.Malpractice	0	864	0	0	0	0	0	0	0	0	0	864	26
27	Other (specify):*	0	37,772	0	0	0	0	0	0	0	0	0	37,772	27
28	TOTAL General Administration	(91,384)	(176,865)	0	0	0	0	0	0	0	0	0	(268,249)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(91,384)	(140,286)	0	0	0	0	0	0	0	0	0	(231,670)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mayfield Care Center

0054528

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	(6,322)	0	0	0	0	0	0	0	0	0	0	(6,322)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(206)	0	0	0	0	0	0	0	0	0	0	(206)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	20,006	0	0	0	0	0	0	0	0	0	20,006	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	(6,528)	20,006	0	13,478	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):*	(106,957)	0	0	0	0	0	0	0	0	0	0	(106,957)	43
44	TOTAL Special Cost Centers	(106,957)	0	0	0	0	0	0	0	0	0	0	(106,957)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(204,869)	(120,280)	0	(325,149)	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 management
Bert Heineman	47.5	Beacon care Center	Chicago	Everest Care Group	Skokie	management
Moshe Levovitz	47.5	Uptown 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Management Fees	\$ 534,674	Everest Care Group	100.00%	\$	\$ (534,674)	1
2	V	5 Utilities				688	688	2
3	V	6 Maintenance Salaries				18,820	18,820	3
4	V	10 Nursing Salaries				4,488	4,488	4
5	V	1 Dietary Wages				12,583	12,583	5
6	V	21 Clerical Wages				105,700	105,700	6
7	V	19 Professional fees				183,326	183,326	7
8	V	21 Office				26,154	26,154	8
9	V	34 Rent				20,006	20,006	9
10	V	26 Insurance				864	864	10
11	V	27 Allocated Benifets				37,772	37,772	11
12	V	25 Auto				3,993	3,993	12
13	V							13
14	Total		\$ 534,674			\$ 414,394	\$ * (120,280)	14

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

Facility Name & ID Number

Mayfield Care Center

0054528

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 Mayfield Care Center # 0054528 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 Mayfield Care Center

0054528

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	\$ 156	\$ 688	1
2	6	Maintenance Wages	Number Of beds	609	3	73,471	73,471	18,820	2
3	10	Nursing Wages	Number Of beds	609	3	17,519	17,519	4,488	3
4	1	Dietary Wages	Number Of beds	609	3	49,123	49,123	12,583	4
5	21	Clerical Wages	Number Of beds	609	3	412,636	412,636	105,700	5
6	19	Professional Fees	Number Of beds	609	3	715,678	156	183,326	6
7	21	Office Supplies	Number Of beds	609	3	102,102	156	26,154	7
8	34	Rent	Number Of beds	609	3	78,100	156	20,006	8
9	26	Insurance	Number Of beds	609	3	3,374	156	864	9
10	27	Allocated Benifets	Number Of beds	609	3	147,455	156	37,772	10
11	25	Auto Expense	Number Of beds	609	3	15,588	156	3,993	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	\$ 414,394	25

Facility Name & ID Number Mayfield Care Center

0054528

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		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						103,953	6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$ 103,953	9							
B. Non-Facility Related*																		
10	Interest Income									(206)	10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$ (206)	14							
15	TOTALS (line 9+line14)					\$	\$			\$ 103,747	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.)

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mayfield Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054528

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>16-08-419-002-0000</u>	<u>Nursing Home</u>	\$ <u>968.70</u>	\$ <u>968.70</u>
2. <u>16-08-419-003-0000</u>	<u>Nursing Home</u>	\$ <u>47,069.80</u>	\$ <u>47,069.80</u>
3. <u>16-08-419-004-0000</u>	<u>Nursing Home</u>	\$ <u>70,584.61</u>	\$ <u>70,584.61</u>
4. <u>16-08-419-005-0000</u>	<u>Nursing Home</u>	\$ <u>48,594.26</u>	\$ <u>48,594.26</u>
5. <u>16-08-419-006-0000</u>	<u>Nursing Home</u>	\$ <u>33,585.34</u>	\$ <u>33,585.34</u>
6. <u>16-08-419-007-0000</u>	<u>Nursing Home</u>	\$ <u>8,761.71</u>	\$ <u>8,761.71</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>209,564.42</u></u>	\$ <u><u>209,564.42</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 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 Mayfield Care Center

0054528

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 4

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

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

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

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

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

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

Empty lines for listing other business entities.

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: 32,172 2. Number of Years Over Which it is Being Amortized: 3
3. Current Period Amortization: 10,724 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: 1, 2, 3, \$, 1. Row 2: 2, 2. Row 3: 3 TOTALS, \$, 3.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9		New Annunciator Pane			4,802	240	20	240		480
10		Building Signs & Awning			6,568	328	20	328		656
11		New Hydraulic Packing In Small Passenger Elevator			2,700	135	20	135		270
12		New sign for facility			12,283	819	15	819		819
13		Pave Parking Lot			3,426	228	15	228		228
14		Install new Air conditioner in Patient rooms			19,931	1,329	15	1,329		1,329
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

Facility Name & ID Number Mayfield Care Center

0054528

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	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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$ 49,710	\$ 3,079		\$ 3,079	\$	\$ 3,782

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

Facility Name & ID Number Mayfield Care Center

0054528

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	\$ 26,489	\$ 2,649	\$ 2,649	\$	10	\$ 5,298	71
72	Current Year Purchases	\$ 35,856	\$ 9,908	\$ 3,586	\$ (6,322)	10	\$ 3,586	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 62,345	\$ 12,557	\$ 6,235	\$ (6,322)		\$ 8,884	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	2018 Bus	2018	\$ 87,954	\$ 8,377	\$ 8,377	\$	7	\$ 8,377	76
77										77
78										78
79										79
80	TOTALS			\$ 87,954	\$ 8,377	\$ 8,377	\$		\$ 8,377	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)	\$ 200,009	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,013	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,691	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,322)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 21,043	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 Mayfield Care Center

0054528

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:				\$			3
4	Additions		156	04/01/2017	1,496,157			4
5	Allocated from everest care Group				20,006			5
6								6
7	TOTAL		156		\$ 1,516,163			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	\$		\$ 289,540	\$		\$ 289,540	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			140,921			140,921	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			270,925			270,925	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				164,620		164,620	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab,Radiology,Oxygen</u>						34,433		34,433	12
13	Other (specify): _____									13
14	TOTAL			\$		\$ 701,386	\$ 199,053		\$ 900,439	14

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

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 30,760	\$	1
2	Cash-Patient Deposits	32,780		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,288,016		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	121,492		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from related parties</u>	360,910		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,833,958	\$	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	49,710		15
16	Equipment, at Historical Cost	150,299		16
17	Accumulated Depreciation (book methods)	(27,868)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	32,172		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(18,767)		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)	\$ 185,546	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,019,504	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,026,921	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,460		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	233,678		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,876		31
32	Accrued Real Estate Taxes(Sch.IX-B)	213,755		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to related Parties</u>	288,517		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,816,207	\$	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)	\$ 2,816,207	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 203,297	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,019,504	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 379,856	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 379,856	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(176,559)	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)	\$ (176,559)	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)	\$ 203,297	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mayfield Care Center

0054528

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,821,976	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,821,976	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***	206	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 206	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)	\$ 10,822,182	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,455,651	31
32	Health Care	3,671,354	32
33	General Administration	2,659,866	33
B. Capital Expense			
34	Ownership	1,854,909	34
C. Ancillary Expense			
35	Special Cost Centers	1,007,396	35
36	Provider Participation Fee	349,565	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,998,741	40
41	Income before Income Taxes (line 30 minus line 40)**	(176,559)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (176,559)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,335,150	44
45	Private Pay - Net Inpatient Revenue	43,344	45
46	Medicare - Net Inpatient Revenue	2,996,989	46
47	Other-(specify) <u>Insurance</u>	148,445	47
48	Other-(specify) <u>Med b</u>	298,048	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,821,976	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 Mayfield Care Center

0054528

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,256	1,397	\$ 133,038	\$ 95.23	1
2	Assistant Director of Nursing	1,488	1,528	59,126	38.70	2
3	Registered Nurses	15,157	16,383	660,368	40.31	3
4	Licensed Practical Nurses	40,203	42,978	1,209,401	28.14	4
5	CNAs & Orderlies	74,393	80,477	1,061,364	13.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,592	1,688	28,483	16.87	9
10	Activity Assistants	9,266	9,938	127,813	12.86	10
11	Social Service Workers	4,228	4,651	99,637	21.42	11
12	Dietician					12
13	Food Service Supervisor	1,257	1,686	66,672	39.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,378	22,012	283,663	12.89	15
16	Dishwashers					16
17	Maintenance Workers	2,409	2,684	64,561	24.05	17
18	Housekeepers	17,994	19,730	246,116	12.47	18
19	Laundry	6,190	7,220	88,169	12.21	19
20	Administrator	1,976	2,208	170,159	77.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,865	20,308	441,396	21.74	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	1,216	1,288	17,280	13.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	217,868	236,176	\$ 4,757,246 *	\$ 20.14	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 11,500	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant	monthly 10,593	10-3	38
39	Pharmacist Consultant			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	20 806	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	20 \$ 22,899		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		
Josh Graber	Administrator		\$ 115,835	Workers' Compensation Insurance	\$ 86,401	IDPH License Fee	\$ 1,990		
Cheryl Nelson	Administrator		54,324	Unemployment Compensation Insurance	92,000	Advertising: Employee Recruitment	696		
				FICA Taxes	363,929	Health Care Worker Background Check	548		
				Employee Health Insurance	253,286	(Indicate # of checks performed 50)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	18,063		
						Illinois Council on LTC	6,240		
						Joint Commision	3,324		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 170,159						
B. Administrative - Other									
Description			Amount						
Everest care group Management fees			\$ 534,674			Less: Public Relations Expense	()		
						Non-allowable advertising	(18,063)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 534,674	TOTAL (agree to Schedule V, line 22, col.8)	\$ 795,616	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,798		
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	
Neal, Gerber & Eisenberg LLP	Legal		\$ 1,805				Out-of-State Travel	\$	
Congressional bank	Legal for loc		4,237						
Carden Tracy & Stolberg	Legal		7,017						
Achieve	Accreditation		11,400				In-State Travel		
Marcum	Accounting		4,635						
Compliance consulting	Consulting		10,200						
Personel Planners	UC Tax Consultant		629				Seminar Expense		
							misc seminars	320	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 39,923	TOTAL		\$	Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 320	

* Attach copy of IMRF notifications

**See instructions.

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. ICLTC \$6240
- (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. \$ 49,480 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. \$ 349,565
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. \$ _____
- (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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees