

Facility Name & ID Number University Care Center, Llc

0054908 Report Period Beginning: 03/01/18 Ending: 12/31/18

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>122</u>	Skilled (SNF)	<u>122</u>	<u>44,530</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>122</u>	TOTALS	<u>122</u>	<u>44,530</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>17,990</u>	<u>3,237</u>	<u>3,651</u>	<u>24,878</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,990</u>	<u>3,237</u>	<u>3,651</u>	<u>24,878</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.87%

D. How many bed reserve days during this year were paid by the Department?

None (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 3/1/2018

J. Was the facility purchased or leased after January 1, 1978?

YES Date 3/1/2018 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 118 and days of care provided 2,274

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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number University Care Center, Llc # 0054908 Report Period Beginning: 03/01/18 Ending: 12/31/18

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	158,607	6,636	7,851	173,094		173,094		173,094		1
2	Food Purchase		146,377		146,377		146,377	(202)	146,175		2
3	Housekeeping	82,175	21,462		103,637		103,637		103,637		3
4	Laundry	59,521	11,230		70,751		70,751		70,751		4
5	Heat and Other Utilities			102,511	102,511		102,511		102,511		5
6	Maintenance	50,520	10,453	51,608	112,581		112,581	727	113,308		6
7	Other (specify):*										7
8	TOTAL General Services	350,823	196,158	161,970	708,951		708,951	525	709,476		8
	B. Health Care and Programs										
9	Medical Director			36,250	36,250		36,250		36,250		9
10	Nursing and Medical Records	1,448,505	15,197	65,230	1,528,932		1,528,932	(187)	1,528,745		10
10a	Therapy										10a
11	Activities	49,624	8,900		58,524		58,524		58,524		11
12	Social Services	33,679		3,086	36,765		36,765	282	37,047		12
13	CNA Training										13
14	Program Transportation			75	75		75		75		14
15	Other (specify):*							60	60		15
16	TOTAL Health Care and Programs	1,531,808	24,097	104,641	1,660,546		1,660,546	155	1,660,701		16
	C. General Administration										
17	Administrative	83,866		20,000	103,866		103,866	8,125	111,991		17
18	Directors Fees										18
19	Professional Services			194,435	194,435		194,435	(137,608)	56,827		19
20	Dues, Fees, Subscriptions & Promotions			45,700	45,700		45,700	(12,056)	33,644		20
21	Clerical & General Office Expenses	100,161	14,078	155,284	269,523		269,523	(20,725)	248,798		21
22	Employee Benefits & Payroll Taxes			404,821	404,821		404,821		404,821		22
23	Inservice Training & Education										23
24	Travel and Seminar			873	873		873	144	1,017		24
25	Other Admin. Staff Transportation			10,665	10,665		10,665	(888)	9,777		25
26	Insurance-Prop.Liab.Malpractice			149,628	149,628		149,628	1,335	150,963		26
27	Other (specify):*							13,565	13,565		27
28	TOTAL General Administration	184,027	14,078	981,406	1,179,511		1,179,511	(148,108)	1,031,403		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,066,658	234,333	1,248,017	3,549,008		3,549,008	(147,427)	3,401,581		29

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

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

Facility Name & ID Number University Care Center, Llc

#0054908

Report Period Beginning:

03/01/18

Ending:

12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			17,405	17,405		17,405	70,545	87,950			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,495	14,495		14,495	67,459	81,954			32
33	Real Estate Taxes			86,059	86,059		86,059		86,059			33
34	Rent-Facility & Grounds			162,446	162,446		162,446	(148,048)	14,398			34
35	Rent-Equipment & Vehicles			12,258	12,258		12,258	3,952	16,210			35
36	Other (specify):*											36
37	TOTAL Ownership			292,663	292,663		292,663	(6,092)	286,571			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		212,550	340,415	552,965		552,965		552,965			39
40	Barber and Beauty Shops			223	223		223		223			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			185,580	185,580		185,580		185,580			42
43	Other (specify):*	43,392		80,000	123,392		123,392	(123,392)				43
44	TOTAL Special Cost Centers	43,392	212,550	606,218	862,160		862,160	(123,392)	738,768			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,110,050	446,883	2,146,898	4,703,831		4,703,831	(276,911)	4,426,920			45

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

University Care Center, Llc

ID# 0054908

Report Period Beginning: 03/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Resident Lost Items	\$ (187)	10	1
2	Marketing Salaries	(43,392)	43	2
3	Medicare Budget Sequestration	(17,749)	21	3
4	Bank Service Charges	(3,955)	21	4
5	Collection Fees/ Cc Fees	(1,730)	21	5
6	Entertainment - Meals	(3,234)	21	6
7	Miscellaneous Income	(5,482)	21	7
8	Additional R&M	8,863	06	8
9	Capitalized R&M	(3,828)	06	9
10	Admin Salaries	(4,056)	21	10
11	Employee Vacation	(1,425)	21	11
12	Meal Tickets	(12)	02	12
13	Building Co - Bank Charges	(20)	21	13
14	Building Co - Amortization	(6,848)	36	14
15	Non-allowable Travel	(3,070)	25	15
16	Non-allowable Expense	(80,000)	43	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	(166,126)		49

University Care Center, Llc

Report Period Beginning: ID# 0054908
 Ending: 03/01/18
 12/31/18

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number University Care Center, Llc# 0054908

Report Period Beginning:

03/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(202)											(202)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(4,708)		5,435									727	6
7	Other (specify):*													7
8	TOTAL General Services	(4,910)		5,435									525	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(187)											(187)	10
10a	Therapy													10a
11	Activities													11
12	Social Services			282									282	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			60									60	15
16	TOTAL Health Care and Programs	(187)		342									155	16
	C. General Administration													
17	Administrative			8,125									8,125	17
18	Directors Fees													18
19	Professional Services			(137,608)									(137,608)	19
20	Fees, Subscriptions & Promotions	(12,465)		409									(12,056)	20
21	Clerical & General Office Expenses	(109,202)	20	88,457									(20,725)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			144									144	24
25	Other Admin. Staff Transportation	(3,070)		2,182									(888)	25
26	Insurance-Prop.Liab.Malpractice			1,335									1,335	26
27	Other (specify):*			13,565									13,565	27
28	TOTAL General Administration	(124,737)	20	(23,391)									(148,108)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(129,834)	20	(17,614)									(147,427)	29

STATE OF ILLINOIS

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning:

03/01/18

Ending:

Summary B

12/31/18

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(46,552)	117,021	76									70,545	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		66,624	835									67,459	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(160,000)	11,952									(148,048)	34
35	Rent-Equipment & Vehicles			3,952									3,952	35
36	Other (specify):*	(6,848)	6,848											36
37	TOTAL Ownership	(53,400)	30,493	16,815									(6,092)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(123,392)											(123,392)	43
44	TOTAL Special Cost Centers	(123,392)											(123,392)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(306,626)	30,513	(799)									(276,911)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	34 Rent Income	\$ 160,000	University Health Properties LLC		\$	(160,000)	1
2	V	21 Bank Service Charges		University Health Properties LLC		20	20	2
3	V	36 Amortization - Loan		University Health Properties LLC		6,848	6,848	3
4	V	30 Depreciation		University Health Properties LLC		117,021	117,021	4
5	V	32 Interest		University Health Properties LLC		66,624	66,624	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 160,000			\$ 190,513	\$ * 30,513	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 REPAIRS & MAINTENANCE	\$	HEALTHCARE ACCOUNTING SERVICES, LLC		\$ 5,435	\$	5,435	15
16	V	19 PROFESSIONAL FEES		HEALTHCARE ACCOUNTING SERVICES, LLC		3,407		3,407	16
17	V	20 DUES, SUBSCRIPTIONS		HEALTHCARE ACCOUNTING SERVICES, LLC		409		409	17
18	V	21 CLERICAL & GENERAL		HEALTHCARE ACCOUNTING SERVICES, LLC		1,152		1,152	18
19	V	24 SEMINAR		HEALTHCARE ACCOUNTING SERVICES, LLC		144		144	19
20	V	25 TRAVEL		HEALTHCARE ACCOUNTING SERVICES, LLC		2,182		2,182	20
21	V	26 INSURANCE		HEALTHCARE ACCOUNTING SERVICES, LLC		1,335		1,335	21
22	V	30 DEPRECIATION		HEALTHCARE ACCOUNTING SERVICES, LLC		76		76	22
23	V	32 INTEREST		HEALTHCARE ACCOUNTING SERVICES, LLC		835		835	23
24	V	34 OFFICE SPACE		HEALTHCARE ACCOUNTING SERVICES, LLC		11,952		11,952	24
25	V	35 AUTO RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC		2,972		2,972	25
26	V	35 EQUIPMENT RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC		980		980	26
27	V	21 CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC		56,555		56,555	27
28	V	27 EMP. BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC		7,838		7,838	28
29	V	17 ADMIN. SALARY - M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC		8,125		8,125	29
30	V	27 EMP. BEN.-M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC		764		764	30
31	V								31
32	V	21 CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC		30,750		30,750	32
33	V	27 EMPLOYEE BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC		4,963		4,963	33
34	V								34
35	V	12 SOCIAL SERVICE		HEALTHCARE ACCOUNTING SERVICES, LLC		282		282	35
36	V	15 HEALTH CARE EMPLOYEE BENEFITS		HEALTHCARE ACCOUNTING SERVICES, LLC		60		60	36
37	V								37
38	V	19 BOOKEEPING SERVICES	141,015					(141,015)	38
39	Total		\$ 141,015			\$ 140,216	\$ *	(799)	39

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

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning: 03/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number University Care Center, Llc

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Report Period Beginning: 03/01/18

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VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning: 03/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning: 03/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning: 03/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning: 03/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

University Care Center, Llc

0054908

Report Period Beginning:

03/01/18

Ending:

12/31/18

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	Mark Suissa	Shareholder	Administrative	90.00%	See Attached	4.88	8.13%	MF/Alloc Sal	\$ 28,125	17-3 / 17-7	1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 28,125		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 University Care Center, Llc

0054908 Report Period Beginning: 03/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning:

03/01/18

Ending: 12/31/18

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 HEALTHCARE ACCOUNTING SERVICES, LLC
 Street Address 1401 S. BRENTWOOD BOULEVARD
 City / State / Zip Code BRENTWOOD, MO. 63144
 Phone Number (314) 963-7570
 Fax Number (314) 963-9030

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	6	REPAIRS & MAINTENANCE	ILL, & MO. PAT. DAYS	306,193	7	\$ 66,895	\$ 24,878	\$ 5,435	1
2	19	PROFESSIONAL FEES	ILL, & MO. PAT. DAYS	306,193	7	41,928	24,878	3,407	2
3	20	DUES, SUBSCRIPTIONS	ILL, & MO. PAT. DAYS	306,193	7	5,030	24,878	409	3
4	21	CLERICAL & GENERAL	ILL, & MO. PAT. DAYS	306,193	7	14,180	24,878	1,152	4
5	24	SEMINAR	ILL, & MO. PAT. DAYS	306,193	7	1,773	24,878	144	5
6	25	TRAVEL	ILL, & MO. PAT. DAYS	306,193	7	26,851	24,878	2,182	6
7	26	INSURANCE	ILL, & MO. PAT. DAYS	306,193	7	16,437	24,878	1,335	7
8	30	DEPRECIATION	ILL, & MO. PAT. DAYS	306,193	7	937	24,878	76	8
9	32	INTEREST	ILL, & MO. PAT. DAYS	306,193	7	10,275	24,878	835	9
10	34	OFFICE SPACE	ILL, & MO. PAT. DAYS	306,193	7	147,104	24,878	11,952	10
11	35	AUTO RENTAL	ILL, & MO. PAT. DAYS	306,193	7	36,585	24,878	2,972	11
12	35	EQUIPMENT RENTAL	ILL, & MO. PAT. DAYS	306,193	7	12,062	24,878	980	12
13	21	CLERICAL SALARIES	ILL, & MO. PAT. DAYS	306,193	7	696,067	696,067	56,555	13
14	27	EMP. BEN. GEN. & ADMIN.	ILL, & MO. PAT. DAYS	306,193	7	96,469	24,878	7,838	14
15	17	ADMIN. SALARY - M. SUISSA	ILL, & MO. PAT. DAYS	306,193	7	100,000	100,000	8,125	15
16	27	EMP. BEN.-M. SUISSA	ILL, & MO. PAT. DAYS	306,193	7	9,398	24,878	764	16
17									17
18	21	CLERICAL SALARIES	ILLINOIS PAT. DAYS	139,325	4	172,211	172,211	30,750	18
19	27	EMPLOYEE BEN. GEN. & ADMIN.	ILLINOIS PAT. DAYS	139,325	4	27,794	24,878	4,963	19
20									20
21	12	SOCIAL SERVICE	SPECIFIC FACIL. DAYS	306,193	7	3,474	3,474	282	21
22	15	HEALTH CARE EMPLOYEE BENEFIT	SPECIFIC FACIL. DAYS	306,193	7	737	24,878	60	22
23									23
24									24
25	TOTALS					\$ 1,486,207	\$ 971,752	\$ 140,216	25

Facility Name & ID Number University Care Center, Llc

0054908 Report Period Beginning: 03/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

Facility Name & ID Number University Care Center, Llc

0054908 Report Period Beginning: 03/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning:

03/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number University Care Center, Llc

0054908 Report Period Beginning: 03/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

Facility Name & ID Number University Care Center, Llc

0054908 Report Period Beginning: 03/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

Facility Name & ID Number University Care Center, Llc

0054908 Report Period Beginning: 03/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning:

03/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number University Care Center, Llc

0054908 Report Period Beginning: 03/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

Facility Name & ID Number

University Care Center, Llc

0054908

Report Period Beginning:

03/01/18

Ending:

12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Central Bank of St Louis		X	Mortgage			\$	\$ 1,952,756		\$ 66,624	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	Central Bank of St Louis		X	Line of Credit				\$ 495,000		\$ 14,495	6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$ 2,447,756		\$ 81,119	9									
B. Non-Facility Related*																				
10	Allocated from HAS		X							\$ 835	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ 835	14									
15	TOTALS (line 9+line14)						\$	\$ 2,447,756		\$ 81,954	15									

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

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

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME University Care Center, Llc COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0054908

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>14-2-15-15-11-201-002.001</u>	<u>Nursing Home</u>	\$ <u>86,059.32</u>	\$ <u>86,059.32</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>86,059.32</u>	\$ <u>86,059.32</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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME University Care Center, Llc COUNTY Madison
 FACILITY IDPH LICENSE NUMBER 0054908
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 University Care Center, Llc

0054908

Report Period Beginning:

03/01/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,920 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>		<u>2018</u>	<u>\$ 245,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 245,000	3

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning:

03/01/18

Ending:

12/31/18

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	122		2018	1978	\$ 2,205,000	\$ 67,021	35	\$ 52,500	\$ (14,521)	\$ 52,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 2,205,000	\$ 84,426		\$ 52,500	\$ (31,926)	\$ 52,500	70

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

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning:

03/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,205,000	\$ 84,426		\$ 52,500	\$ (31,926)	\$ 52,500	1
2	Amana Digismart Ptac Heating Units X 11	2018	7,307		20	365	365	365	2
3	Hvac Rooftops Units X 5	2018	30,775		20	1,539	1,539	1,539	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,243,082	\$ 84,426		\$ 54,404	\$ (30,022)	\$ 54,404	34

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

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning:

03/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,243,082	\$ 84,426		\$ 54,404	\$ (30,022)	\$ 54,404	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,243,082	\$ 84,426		\$ 54,404	\$ (30,022)	\$ 54,404	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,243,082	\$ 84,426		\$ 54,404	\$ (30,022)	\$ 54,404	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,243,082	\$ 84,426		\$ 54,404	\$ (30,022)	\$ 54,404	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,243,082	\$ 84,426		\$ 54,404	\$ (30,022)	\$ 54,404	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,243,082	\$ 84,426		\$ 54,404	\$ (30,022)	\$ 54,404	34

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

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning:

03/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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	\$ 936	\$ 76	\$ 94	\$ 18	10	\$ 593	71
72	Current Year Purchases	\$ 364,527	\$ 50,000	\$ 31,453	(18,547)	10	\$ 31,453	72
73	Fully Depreciated Assets	\$ 11,398				10	\$ 11,398	73
74								74
75	TOTALS	\$ 376,862	\$ 50,076	\$ 31,546	\$ (18,530)		\$ 43,444	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		Facility Van	2018	\$ 10,000	\$	\$ 2,000	\$ 2,000	5	\$ 2,000	76
77										77
78										78
79										79
80	TOTALS			\$ 10,000	\$	\$ 2,000	\$ 2,000		\$ 2,000	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)	\$ 2,874,943	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 134,502	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 87,950	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (46,552)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 99,848	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from HAS				11,952			5
6	Storage				2,446			6
7	TOTAL				\$ 14,398			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: \$ 9,860 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Lincoln	\$ 685.36	\$ 3,377	17
18	Allocated from HAS			2,972	18
19					19
20					20
21	TOTAL		\$ 685.36	\$ 6,349	21

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

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

Facility Name & ID Number University Care Center, Llc # 0054908 Report Period Beginning: 03/01/18 Ending: 12/31/18
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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs		\$			\$	156,512	\$			\$	156,512	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					\$	50,550					50,550	2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	39 - 03	hrs						127,120					127,120	4	
5	Physician Care		visits												5	
6	Dental Care		visits												6	
7	Work Related Program		hrs												7	
8	Habilitation		hrs												8	
9	Pharmacy	39 - 02	# of prescripts							116,879				116,879	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Other (specify):														12	
13	Other (specify):								6,233	95,671				101,904	13	
14	TOTAL				\$			\$	340,415	\$	212,550		\$	552,965	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.

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning: 03/01/18

Ending:

12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 129,639	\$ 145,089	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,279,113	1,279,113	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,450	33,450	6
7	Other Prepaid Expenses	16,445	16,445	7
8	Accounts Receivable (owners or related parties)		5,661	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,459,147	\$ 1,480,258	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		245,000	13
14	Buildings, at Historical Cost		2,205,000	14
15	Leasehold Improvements, at Historical Cost	39,819	39,819	15
16	Equipment, at Historical Cost	81,653	381,653	16
17	Accumulated Depreciation (book methods)	(17,405)	(134,426)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		41,085	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,848)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	192,274	316,499	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 296,341	\$ 3,087,782	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,755,488	\$ 4,568,040	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 671,550	\$ 671,550	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,856	18,856	28
29	Short-Term Notes Payable	495,000	595,571	29
30	Accrued Salaries Payable	180,126	180,126	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,834	13,834	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	122,276	122,276	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,501,642	\$ 1,602,213	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,852,185	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	266,480	293,361	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 266,480	\$ 2,145,546	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,768,122	\$ 3,747,759	46
47	TOTAL EQUITY(page 18, line 24)	\$ (12,634)	\$ 820,281	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,755,488	\$ 4,568,040	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(91,675)	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	79,041	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)	\$ (12,634)	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)	\$ (12,634)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning: 03/01/18

Ending: 12/31/18

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	\$ 4,316,265	1
2	Discounts and Allowances for all Levels	(528,537)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,787,728	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	696,258	6
7	Oxygen	6,177	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 702,435	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	104,788	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,012	19
20	Radiology and X-Ray	4,699	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 116,499	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	5,494	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,494	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,612,156	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	708,951	31
32	Health Care	1,660,546	32
33	General Administration	1,179,511	33
B. Capital Expense			
34	Ownership	292,663	34
C. Ancillary Expense			
35	Special Cost Centers	676,580	35
36	Provider Participation Fee	185,580	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,703,831	40
41	Income before Income Taxes (line 30 minus line 40)**	(91,675)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (91,675)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,443,988	44
45	Private Pay - Net Inpatient Revenue	574,530	45
46	Medicare - Net Inpatient Revenue	513,184	46
47	Other-(specify)	(100,799)	47
48	Other-(specify) <u>Insurance</u>	356,825	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,787,728	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

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

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

Facility Name & ID Number University Care Center, Llc

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Report Period Beginning: 03/01/18

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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	1,644	1,768	\$ 76,181	\$ 43.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,823	7,337	215,927	29.43	3
4	Licensed Practical Nurses	16,397	17,631	460,801	26.14	4
5	CNAs & Orderlies	44,287	47,620	676,069	14.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,024	4,327	49,624	11.47	10
11	Social Service Workers	1,742	1,873	33,679	17.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,881	12,775	158,607	12.42	15
16	Dishwashers					16
17	Maintenance Workers	2,730	2,936	50,520	17.21	17
18	Housekeepers	7,292	7,841	82,175	10.48	18
19	Laundry	4,846	5,211	59,521	11.42	19
20	Administrator	1,748	1,880	83,866	44.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,311	3,560	100,161	28.14	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	1,171	1,259	19,527	15.51	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	1,312	1,411	43,392	30.75	33
34	TOTAL (lines 1 - 33)	109,208	117,429	\$ 2,110,050 *	\$ 17.97	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	133	\$ 7,851	01-03	35
36	Medical Director	Monthly	36,250	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	10,614	10-03	38
39	Pharmacist Consultant	75	5,022	10-03	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	47	3,086	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	255	\$ 62,823		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	1,929	49,594	10-03	52
53	TOTAL (lines 50 - 52)	1,929	\$ 49,594		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		
Terrie Weible	Administrator	0	\$ 74,141	Workers' Compensation Insurance	\$ 75,597	IDPH License Fee	\$ 995		
Regina White	Administrator	0	9,725	Unemployment Compensation Insurance	50,027	Advertising: Employee Recruitment	13,849		
				FICA Taxes	158,168	Health Care Worker Background Check	6,950		
				Employee Health Insurance	106,891	(Indicate # of checks performed 143)			
				Employee Meals		Patient Background Checks	129 2,076		
				Illinois Municipal Retirement Fund (IMRF)*		Dues And Subscriptions	2,694		
				Employer 401K Match/Pension	1,722	Licenses And Fees	6,671		
				Employee Medical Expenses	220	Allocated from HAS	409		
				Holiday Expense - Employee	12,196				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,866	TOTAL (agree to Schedule V, line 22, col.8)		\$ 404,821			
B. Administrative - Other							Less: Public Relations Expense ()		
Description			Amount				Non-allowable advertising ()		
Management Fees -Mark Suissa			\$ 20,000				Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 20,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			TOTAL (agree to Sch. V, line 20, col. 8)		
C. Professional Services							G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Attached	Legal Fees		\$ 24,535				Out-of-State Travel	\$	
Marcum LLP	Accounting Fees		3,476						
M S Healthcare Accounting	Accounting Fees		3,250				In-State Travel		
Healthcare Accounting Services	Accounting/Bookkeeping		141,015						
National Datacare Corporation	Data Processing		2,079						
Paycom	Payroll Processing		14,235				Seminar Expense	873	
Ability Network Inc.	IT Consulting		3,455				Allocated from HAS	144	
TASC	Enrollment Services		1,925						
American Funds 401k	Recordkeeping		466				Entertainment Expense ()		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 194,436	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,017

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number University Care Center, Llc

0054908

Report Period Beginning:

03/01/18

Ending: 12/31/18

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,769 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. N/A
- (9) Are you presently operating under a sublease agreement? X YES 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. \$ 185,580
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? 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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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