FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0049809

Facility Name: PAVILION OF WAUKEGAN

Address: 2217 WASHINGTON STREET (Number) WAUKEGAN (City) 60085 (Zip Code)

County: LAKE

Telephone Number: (847) 244-4100 **Fax #** (847) 244-2183

HFS ID Number:

Date of Initial License for Current Owners: 12/1/07

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: DARRYL BUEKER **Telephone Number:** (417) 865-8701
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) DARRYL BUEKER, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,785	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	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,288	1,503	7,993	33,784	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,288	1,503	7,993	33,784	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.92%

D. How many bed-hold days during this year were paid by the Department?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/1/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 109 and days of care provided 6,167

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	204,395	12,859	6,925	224,179		224,179		224,179			1
2	Food Purchase		167,683		167,683		167,683		167,683			2
3	Housekeeping	115,928	36,297		152,225		152,225		152,225			3
4	Laundry	48,278	12,661		60,939		60,939		60,939			4
5	Heat and Other Utilities			93,603	93,603		93,603		93,603			5
6	Maintenance	69,254	8,804	48,408	126,466		126,466		126,466			6
7	Other (specify):*											7
8	TOTAL General Services	437,855	238,304	148,936	825,095		825,095		825,095			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,848,363	207,833	6,032	2,062,228		2,062,228		2,062,228			10
10a	Therapy	130,690	105	529,731	660,526		660,526		660,526			10a
11	Activities	90,548	3,997	10,062	104,607		104,607		104,607			11
12	Social Services	45,478			45,478		45,478		45,478			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,115,079	211,935	557,825	2,884,839		2,884,839		2,884,839			16
	C. General Administration											
17	Administrative	59,221		484,250	543,471		543,471	(256,495)	286,976			17
18	Directors Fees											18
19	Professional Services			76,614	76,614		76,614	7,693	84,307			19
20	Dues, Fees, Subscriptions & Promotions			25,877	25,877		25,877	(11,972)	13,905			20
21	Clerical & General Office Expenses	162,414	26,941	44,137	233,492		233,492	109,532	343,024			21
22	Employee Benefits & Payroll Taxes			464,299	464,299		464,299		464,299			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,748	8,748		8,748		8,748			24
25	Other Admin. Staff Transportation			16,986	16,986		16,986	14,975	31,961			25
26	Insurance-Prop.Liab.Malpractice			92,620	92,620		92,620	612	93,232			26
27	Other (specify):*							12,564	12,564			27
28	TOTAL General Administration	221,635	26,941	1,213,531	1,462,107		1,462,107	(123,091)	1,339,016			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,774,569	477,180	1,920,292	5,172,041		5,172,041	(123,091)	5,048,950			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 PAVILION OF WAUKEGAN #0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			31,617	31,617		31,617	1,798	33,415			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,821	51,821		51,821	(772)	51,049			32
33	Real Estate Taxes			90,000	90,000		90,000		90,000			33
34	Rent-Facility & Grounds			498,970	498,970		498,970	4,202	503,172			34
35	Rent-Equipment & Vehicles			114,308	114,308		114,308	1,334	115,642			35
36	Other (specify):*											36
37	**TOTAL Ownership**			786,716	786,716		786,716	6,562	793,278			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			393,749	393,749		393,749		393,749			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,678	59,678		59,678		59,678			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			453,427	453,427		453,427		453,427			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,774,569	477,180	3,160,435	6,412,184		6,412,184	(116,529)	6,295,655			45

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(93)	32		10
11	Discounts, Allowances, Rebates & Refunds	(16,411)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		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	(5,968)	21		18
19	Entertainment	(66)	21		19
20	Contributions	(7,250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,084)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(495)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,351)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (43,718)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(72,811)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (72,811)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (116,529)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PAVILION OF WAUKEGAN

ID# 0049809

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$ (4,023)	20	1
2	MISC INCOME-DISCOUNTS	(397)	21	2
3	MISC INCOME-INTEREST	(931)	32	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**	(5,351)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(256,495)	0	0	0	0	0	0	0	0	(256,495)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	7,693	0	0	0	0	0	0	0	0	7,693	19
20	Fees, Subscriptions & Promotions	(12,107)	0	135	0	0	0	0	0	0	0	0	(11,972)	20
21	Clerical & General Office Expenses	(30,587)	0	140,119	0	0	0	0	0	0	0	0	109,532	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	0	14,975	0	0	0	0	0	0	0	0	14,975	25
26	Insurance-Prop.Liab.Malpractice	0	0	612	0	0	0	0	0	0	0	0	612	26
27	Other (specify):*	0	0	12,564	0	0	0	0	0	0	0	0	12,564	27
28	**TOTAL General Administration**	(42,694)	0	(80,397)	0	0	0	0	0	0	0	0	(123,091)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(42,694)	0	(80,397)	0	0	0	0	0	0	0	0	(123,091)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	1,798	0	0	0	0	0	0	0	0	1,798	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,024)	0	252	0	0	0	0	0	0	0	0	(772)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	4,202	0	0	0	0	0	0	0	0	4,202	34
35	Rent-Equipment & Vehicles	0	0	1,334	0	0	0	0	0	0	0	0	1,334	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,024)	0	7,586	0	0	0	0	0	0	0	0	6,562	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(43,718)	0	(72,811)	0	0	0	0	0	0	0	0	(116,529)	45

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 498,970	PAVILION OF WAUKEGAN REALTY, LLC		$ 498,970	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V	19	LEGAL FEES	1,254	LAW OFFICE OF ABRAHAM GUTNICKI		1,254		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 500,224			$ 500,224	$ *	14

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	HOME OFFICE	$ 364,250	AA HEALTHCARE MANAGEMENT, LLC	100.00%	$	$ (364,250)	15
16	V	5	Utilities		AA HEALTHCARE MANAGEMENT, LLC				16
17	V	6	Repairs & Maintenance		AA HEALTHCARE MANAGEMENT, LLC				17
18	V	17	Owners Compensation		AA HEALTHCARE MANAGEMENT, LLC		107,755	107,755	18
19	V	19	Professional Fees		AA HEALTHCARE MANAGEMENT, LLC		7,693	7,693	19
20	V	20	Fees, Subscriptions		AA HEALTHCARE MANAGEMENT, LLC		135	135	20
21	V	21	Clerical Salaries		AA HEALTHCARE MANAGEMENT, LLC		137,200	137,200	21
22	V	21	Office Expenses		AA HEALTHCARE MANAGEMENT, LLC		2,919	2,919	22
23	V	24	Travel & Seminars		AA HEALTHCARE MANAGEMENT, LLC				23
24	V	25	Transportation		AA HEALTHCARE MANAGEMENT, LLC		14,975	14,975	24
25	V	26	Insurance		AA HEALTHCARE MANAGEMENT, LLC		612	612	25
26	V	27	Employee Benefits		AA HEALTHCARE MANAGEMENT, LLC		12,564	12,564	26
27	V	30	Depreciation		AA HEALTHCARE MANAGEMENT, LLC		1,798	1,798	27
28	V	32	Interest		AA HEALTHCARE MANAGEMENT, LLC		252	252	28
29	V	34	Rent		AA HEALTHCARE MANAGEMENT, LLC		4,202	4,202	29
30	V	35	Equipment Rental		AA HEALTHCARE MANAGEMENT, LLC		1,334	1,334	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			$ 364,250			$ 291,439	$ * (72,811)	39

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AARON TOPPER	OWNER/ADMIN	Administrative	75.00	SEE ATTACHED	40	80.00	Mgt Fees	$ 107,755	17-3	1
2											2
3	AARON TOPPER	OWNER/ADMIN	Administrative	75.00	SEE ATTACHED			Mgt Fees	90,000	17-3	3
4	ABRAHAM GUTNICKI	OWNER		23.50				Mgt Fees	30,000	17-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 227,755		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 PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: AA HEALTHCARE MANAGEMENT
Street Address: 8320 SKOKIE BLVD. SUITE 18
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 983-4860
Fax Number: (847) 673-3379

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2								33,784		2
3	17	Owners Compensation	Patient Days	62,705	2	200,000		33,784	107,755	3
4	19	Professional Fees	Patient Days	62,705	2	14,279		33,784	7,693	4
5	20	Fees, Subscriptions	Patient Days	62,705	2	250		33,784	135	5
6	21	Clerical Salaries	Patient Days	62,705	2	254,650	254,650	33,784	137,200	6
7	21	Office Expenses	Patient Days	62,705	2	5,418		33,784	2,919	7
8	24	Travel & Seminars	Patient Days	62,705	2			33,784	0	8
9	25	Transportation	Patient Days	62,705	2	27,794		33,784	14,975	9
10	26	Insurance	Patient Days	62,705	2	1,136		33,784	612	10
11	27	Employee Benefits	Patient Days	62,705	2	23,320		33,784	12,564	11
12	30	Depreciation	Patient Days	62,705	2	3,338		33,784	1,798	12
13	32	Interest	Patient Days	62,705	2	467		33,784	252	13
14	34	Rent	Patient Days	62,705	2	7,800		33,784	4,202	14
15	35	Equipment Rental	Patient Days	62,705	2	2,476		33,784	1,334	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 540,928	$ 254,650		$ 291,439	25

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FIFTH THIRD BANK		X	VEHICLE	$333.71		$	$			$ 948	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LAKE FOREST BANK		X	LINE OF CREDIT							45,339	6
7												7
8	MISC										5,534	8
9	TOTAL Facility Related				$333.71		$	$			$ 51,821	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(1,024)	10
11												11
12												12
13	ALLOCATION FROM AA HC MGT										252	13
14	TOTAL Non-Facility Related						$	$			$ (772)	14
15	TOTALS (line 9+line14)						$	$			$ 51,049	15

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

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

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 77,004	2
3. Under or (over) accrual (line 2 minus line 1).		$ 77,004	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 77,004	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	61,950	8
2006		9
2007	63,829	10
2008	74,290	11
2009	77,004	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PAVILION OF WAUKEGAN COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0049809

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20-300-044	NURSING HOME	$ 72,259.96	$ 72,259.96
2.	08-20-311-001	NURSING HOME	$ 4,743.76	$ 4,743.76
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 77,003.72	$ 77,003.72

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,161 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

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

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

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

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

1. Total Amount Incurred: 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	NURSING HOME	36,213		$	1
2					2
3	TOTALS	36,213		$	3

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELECTRIC			2008	10,292	264	39	264		682	9
10	LANDSCAPING			2008	5,106	255	20	255		617	10
11	DOOR KICKPLATES			2009	1,913	191	10	191		303	11
12	ELEVATOR PUMP			2009	1,462	146	10	146		244	12
13	THERMOSTATIC MIXING VALVE			2009	3,955	102	39	102		135	13
14	DOOR ALARM SYSTEM			2009	1,089	109	10	109		136	14
15	CIRCULATING PUMP-HOT WATER HEATER			2009	1,041	104	10	104		113	15
16	SPACE PAK UNIT MOTOR			2010	1,757	161	10	161		161	16
17	LOCKINVAR			2010	8,942	447	15	447		447	17
18	NEW LOCKS			2010	1,417	47	10	47		47	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 36,974	$ 1,826		$ 1,826	$	$ 2,885	70

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 179,708	$ 23,076	$ 23,076	$		$ 53,526	71
72	Current Year Purchases	25,500	3,174	3,174			3,174	72
73	Fully Depreciated Assets							73
74	ALLOC FROM AA HC MGT		1,798	1,798				74
75	TOTALS	$ 205,208	$ 28,048	$ 28,048	$		$ 56,700	75

D. Vehicle Depreciation (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		2004 TOYOTA CAMRY	2008	$ 14,162	$ 3,541	$ 3,541	$	4	$ 7,081	76
77										77
78										78
79										79
80	TOTALS			$ 14,162	$ 3,541	$ 3,541	$		$ 7,081	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)	$ 256,344	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 33,415	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 33,415	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 66,666	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 PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ $114,308 Description: Medical equip $113,408; Dish machine $900
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	hrs	$		$ 247,069	$		$ 247,069	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			86,124			86,124	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			195,562	105		195,667	4
5	Physician Care	39-02	visits			(175)			(175)	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				285,144		285,144	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RT	10a-03			10	609		10	609	12
13	Other (specify): Lab/Dialysis	39-02					108,780		108,780	13
14	TOTAL			$	10	$ 529,189	$ 394,029	10	$ 923,218	14

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

STATE OF ILLINOIS

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (24,543)	$	1
2	Cash-Patient Deposits	30,089		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,148,681		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,243		6
7	Other Prepaid Expenses	6,459		7
8	Accounts Receivable (owners or related parties)	30,207		8
9	Other(specify): Deposit	13,595		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,227,731	$	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	36,974		15
16	Equipment, at Historical Cost	219,371		16
17	Accumulated Depreciation (book methods)	(66,665)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 189,680	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,417,411	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 860,808	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,300		28
29	Short-Term Notes Payable	697,022		29
30	Accrued Salaries Payable	166,364		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,054		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	18,171		36
37	Due Others	(388,552)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,402,167	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,258		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)**	$ 5,258	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,407,425	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,986	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,417,411	$	48

*(See instructions.)

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 167,796	1
2	Restatements (describe):		2
3	PRIOR PERIOD ADJUSTMENTS	(26,067)	3
4	ROUNDING	(2)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 141,727	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	66,817	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	(198,558)	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)**	$ (131,741)	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)**	$ 9,986	24 *

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,848,299	1
2	Discounts and Allowances for all Levels	675,469	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,523,768	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	711,535	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 711,535	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	(83)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	204,324	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,625	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 225,866	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	93	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 93	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Inc, Discounts	17,739	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,739	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,479,001	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	825,095	31
32	Health Care	2,884,839	32
33	General Administration	1,462,107	33
	B. Capital Expense		
34	Ownership	786,716	34
	C. Ancillary Expense		
35	Special Cost Centers	393,749	35
36	Provider Participation Fee	59,678	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,412,184	40
41	**Income before Income Taxes (line 30 minus line 40)****	66,817	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 66,817	43

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

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

TAX RETURN FILED ON CASH BASIS

*** **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 PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,264	$ 85,189	$ 37.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,537	26,049	768,600	29.51	3
4	Licensed Practical Nurses	9,627	9,887	257,884	26.08	4
5	CNAs & Orderlies	63,003	64,785	710,481	10.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,361	8,733	130,690	14.97	8
9	Activity Director	1,904	2,080	30,044	14.44	9
10	Activity Assistants	6,821	7,028	60,504	8.61	10
11	Social Service Workers	1,928	1,968	45,478	23.11	11
12	Dietician					12
13	Food Service Supervisor	2,888	3,120	65,246	20.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,663	14,044	139,149	9.91	15
16	Dishwashers					16
17	Maintenance Workers	4,907	5,054	69,254	13.70	17
18	Housekeepers	13,896	13,945	115,928	8.31	18
19	Laundry	4,870	4,968	48,278	9.72	19
20	Administrator					20
21	Assistant Administrator	2,008	2,232	59,221	26.53	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,471	10,870	162,414	14.94	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	1,864	1,960	26,209	13.37	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,828	178,987	$ 2,774,569 *	$ 15.50	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	139	$ 6,925	01-03	35
36	Medical Director		12,000	09-03	36
37	Medical Records Consultant	95	4,592	10-03	37
38	Nurse Consultant		1,440	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	3	367	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,664	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	269	$ 26,988		49

C. CONTRACT NURSES

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
AARON TOPPER	ADMINISTRATOR	75	$ 0
PEARL COLES	ASST ADMIN	0	59,221
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,221

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 120,000
HOME OFFICE	364,250
TOTAL (agree to Schedule V, line 17, col. 3)	$ 484,250
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ABRAHAM GUTNICKI	LEGAL	$ 1,254
MEYER MAGENCE	LEGAL	5,391
LAKE FOREST BANK	LOC RENEWAL FEE	925
BKD	ACCOUNTING	34,295
VARIOUS	COMP/DATA PROC	30,484
PERFECT STAFFING	RECRUITMENT FEES	2,000
ANTONIO NATAL	CONSULTANT	250
PERSONNEL PLANNERS	UNEMP CONSULTING	1,700
SAS ARCHITECTS & PLANNERS	ARCHITECT	315
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 76,614

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,110
Unemployment Compensation Insurance	44,853
FICA Taxes	209,180
Employee Health Insurance	99,530
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS-OTHER	19,881
EMPLOYEE DOCTOR	645
UNIFORMS	3,100
TOTAL (agree to Schedule V, line 22, col.8)	$ 464,299

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,333
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
ADVERTISING & MARKETING	8,084
DUES & SUBSCRIPTIONS	7,428
LICENSES	4,009
ALLOCATION FROM AA HC MGT	135
Less: Public Relations Expense	( )
Non-allowable advertising	(8,084)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,905

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,748
ALLOCATION FROM AA HC MGT	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,748

**See instructions.

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PAVILION OF WAUKEGAN **#** 0049809 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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? **YES**
If YES, give association name and amount. **IL COUNCIL LTC $9,941**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **3-10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,800** Line **10-2**

(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. $ **59,678**
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?
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?
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.