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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0049809

Facility Name: PAVILION OF WAUKEGAN

Address: 2217 WASHINGTON ST (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: 12/01/07

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: Mendel S. Schneider **Telephone Number:** 847-933-1274
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2014 to 12/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) (Date)
(Print Name and Title) See Accountant's Report Attached
(Firm Name & Address) Mendel S. Schneider C.P.A. & Associates, P.C.
4051 Old Orchard Rd, Skokie, IL 60076
(Telephone) (847)933-1274 Fax # (847)933-1283

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	2,044	150	8,667	10,861	8
9	SNF/PED					9
10	ICF	20,000	1,201	765	21,966	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,044	1,351	9,432	32,827	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.51%

D. How many bed-hold days during this year were paid by the Department?
0 (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)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/01/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/07 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 5,586

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 Fiscal Year: 12/31

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	208,400	25,113	7,225	240,738		240,738		240,738			1
2	Food Purchase		177,688		177,688		177,688		177,688			2
3	Housekeeping	114,764	37,587		152,351		152,351		152,351			3
4	Laundry	37,605	9,393	10,076	57,074		57,074		57,074			4
5	Heat and Other Utilities			83,795	83,795		83,795		83,795			5
6	Maintenance	64,578		86,387	150,965		150,965		150,965			6
7	Other (specify):*											7
8	TOTAL General Services	425,347	249,781	187,483	862,611		862,611		862,611			8
	B. Health Care and Programs											
9	Medical Director			36,300	36,300		36,300		36,300			9
10	Nursing and Medical Records	1,953,592	342,776	21,400	2,317,768		2,317,768		2,317,768			10
10a	Therapy		572,011		572,011		572,011		572,011			10a
11	Activities	73,416	4,736	2,090	80,242		80,242		80,242			11
12	Social Services	54,493			54,493		54,493		54,493			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,081,501	919,523	59,790	3,060,814		3,060,814		3,060,814			16
	C. General Administration											
17	Administrative	135,548		354,346	489,894		489,894	(232,208)	257,686			17
18	Directors Fees											18
19	Professional Services			52,845	52,845		52,845	20,879	73,724			19
20	Dues, Fees, Subscriptions & Promotions			80,314	80,314		80,314	(39,382)	40,932			20
21	Clerical & General Office Expenses	163,101	12,393	132,712	308,206		308,206	95,578	403,784			21
22	Employee Benefits & Payroll Taxes			463,227	463,227		463,227		463,227			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,659	8,659		8,659	7,490	16,149			24
25	Other Admin. Staff Transportation							10,809	10,809			25
26	Insurance-Prop.Liab.Malpractice			133,039	133,039		133,039	1,262	134,301			26
27	Other (specify):*							8,839	8,839			27
28	TOTAL General Administration	298,649	12,393	1,225,142	1,536,184		1,536,184	(126,733)	1,409,451			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,805,497	1,181,697	1,472,415	5,459,609		5,459,609	(126,733)	5,332,876			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:** 01/01/2014 **Ending:** 12/31/2014

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			64,646	64,646		64,646	194,170	258,816			30
31	Amortization of Pre-Op. & Org.							15,866	15,866			31
32	Interest			70,383	70,383		70,383	201,399	271,782			32
33	Real Estate Taxes							85,099	85,099			33
34	Rent-Facility & Grounds			503,307	503,307		503,307	(490,317)	12,990			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			638,336	638,336		638,336	6,217	644,553			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			231,067	231,067		231,067		231,067			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,030	225,030		225,030		225,030			42
43	Other (specify):* **Bad Debt Expense**			129,058	129,058		129,058	(129,058)				43
44	**TOTAL Special Cost Centers**			585,155	585,155		585,155	(129,058)	456,097			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,805,497	1,181,697	2,695,906	6,683,100		6,683,100	(249,574)	6,433,526			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: 01/01/2014 Ending: 12/31/2014

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	43,537	30		9
10	Interest and Other Investment Income	(432)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(11,393)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(129,058)	43		24
25	Fund Raising, Advertising and Promotional	(61,969)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (159,315)		$	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)	(90,259)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (90,259)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (249,574)		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: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(232,208)	0	0	0	0	0	0	0	0	(232,208)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	20,879	0	0	0	0	0	0	0	0	20,879	19
20	Fees, Subscriptions & Promotions	(61,969)	0	22,587	0	0	0	0	0	0	0	0	(39,382)	20
21	Clerical & General Office Expenses	(11,393)	0	106,971	0	0	0	0	0	0	0	0	95,578	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	7,490	0	0	0	0	0	0	0	0	7,490	24
25	Other Admin. Staff Transportation	0	0	10,809	0	0	0	0	0	0	0	0	10,809	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,262	0	0	0	0	0	0	0	0	1,262	26
27	Other (specify):*	0	0	8,839	0	0	0	0	0	0	0	0	8,839	27
28	**TOTAL General Administration**	(73,362)	0	(53,371)	0	0	0	0	0	0	0	0	(126,733)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(73,362)	0	(53,371)	0	0	0	0	0	0	0	0	(126,733)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	43,537	150,545	88	0	0	0	0	0	0	0	0	194,170	30
31	Amortization of Pre-Op. & Org.	0	15,866	0	0	0	0	0	0	0	0	0	15,866	31
32	Interest	(432)	201,831	0	0	0	0	0	0	0	0	0	201,399	32
33	Real Estate Taxes	0	85,099	0	0	0	0	0	0	0	0	0	85,099	33
34	Rent-Facility & Grounds	0	(503,307)	12,990	0	0	0	0	0	0	0	0	(490,317)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	43,105	(49,966)	13,078	0	0	0	0	0	0	0	0	6,217	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):*	(129,058)	0	0	0	0	0	0	0	0	0	0	(129,058)	43
44	TOTAL Special Cost Centers	(129,058)	0	0	0	0	0	0	0	0	0	0	(129,058)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(159,315)	(49,966)	(40,293)	0	0	0	0	0	0	0	0	(249,574)	45

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
Aaron Topper	75	Crossroads Care Center of Woodstock	Woodstock	Pavilion of Waukegan Realty		Bldg Rental
Joseph Brandman	25	Park Place of Belvidere	Belvidere	AA Healthcare Management		Management

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	$ 503,307	Pavilion Of Waukegan Realty	100.00%	$	$ (503,307)	1
2	V	32	Interest		Pavilion Of Waukegan Realty	100.00%	201,831	201,831	2
3	V	33	Real Estate Taxes		Pavilion Of Waukegan Realty	100.00%	85,099	85,099	3
4	V	30	Depreciation		Pavilion Of Waukegan Realty	100.00%	150,545	150,545	4
5	V	31	Amortization		Pavilion Of Waukegan Realty	100.00%	15,866	15,866	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			$ 503,307			$ 453,341	$ * (49,966)	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: 01/01/2014 Ending: 12/31/2014

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 Exepnse	$ 354,346	AA Healthcare Management	100.00%	$	$ (354,346)	15
16	V	34	Rent		AA Healthcare Management		12,990	12,990	16
17	V	19	Professional Fees		AA Healthcare Management		20,879	20,879	17
18	V	20	Fees, Subscriptions		AA Healthcare Management		22,587	22,587	18
19	V	21	Clerical Salaries		AA Healthcare Management		91,547	91,547	19
20	V	21	Office Expenses		AA Healthcare Management		15,424	15,424	20
21	V	24	Travel & Seminars		AA Healthcare Management		7,490	7,490	21
22	V	25	Transportation		AA Healthcare Management		10,809	10,809	22
23	V	27	Employee Benefits		AA Healthcare Management		8,839	8,839	23
24	V	30	Depreciation		AA Healthcare Management		88	88	24
25	V	17	Owners Compensation		AA Healthcare Management		122,138	122,138	25
26	V	26	Insurance		AA Healthcare Management		1,262	1,262	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			$ 354,346			$ 314,053	$ * (40,293)	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: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Manager	Management	75.00	272,318	20	40.00	Mgmt Fees	$ 122,138	17	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 122,138		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: 01/01/2014 Ending: 2/31/2014

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: 8140 N . Mccormick Blvd, ste 131
City / State / Zip Code: Skokie, Il 60076
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	17	Owners compensation	Number of Beds	224		$ 251,000	$ 251,000	109	$ 122,138	1
2	34	Rent	Number of Beds	224		26,696		109	12,990	2
3	19	Professional fees	Number of Beds	224		42,908		109	20,879	3
4	20	Fees, Subscriptions	Number of Beds	224		46,417		109	22,587	4
5	21	Clerical Salaries	Number of Beds	224		188,133	188,133	109	91,547	5
6	21	Office Expenses	Number of Beds	224		31,698		109	15,424	6
7	24	Travel & Seminars	Number of Beds	224		15,392		109	7,490	7
8	25	Transportation	Number of Beds	224		22,212		109	10,809	8
9	27	Employee Benefits	Number of Beds	224		18,165		109	8,839	9
10	30	Depreciation	Number of Beds	224		180		109	88	10
11	26	Insurance	Number of Beds	224		2,593		109	1,262	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					$ 645,394	$ 439,133		$ 314,053	25

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	M.B. Bank		X	Mortgage	$23,429.29	10/31/13	$ 4,600,000	$		4.0000	$ 189,307	1
2	M.B. Bank		X	Mortgage		10/31/13	959,250			4.0000	12,524	2
3												3
4												4
5												5
	Working Capital											
6	M.B. Bank		X	Working Capital				998,325		5.0000	70,383	6
7												7
8												8
9	TOTAL Facility Related				$23,429.29		$ 5,559,250	$ 998,325			$ 272,214	9
	B. Non-Facility Related*											
10	Interest Income										(432)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (432)	14
15	TOTALS (line 9+line14)						$ 5,559,250	$ 998,325			$ 271,782	15

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

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

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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.)		$ 85,099	2
3. Under or (over) accrual (line 2 minus line 1).		$ 85,099	3
4. Real Estate Tax accrual used for 2014 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.		$ 85,099	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	77,004	8
	2010	89,251	9
	2011	83,312	10
	2012	108,651	11
	2013	85,099	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PAVILION OF WAUKEGAN COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0049809

CONTACT PERSON REGARDING THIS REPORT Aaron topper

TELEPHONE (847)983-4860 FAX #: (847)673-3379

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20-300-044	Facility	$ 79,413.00	$ 79,413.00
2.	08-20-311-001	Facility	$ 5,686.00	$ 5,686.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 85,099.00	$ 85,099.00

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

1. Total Amount Incurred: 482,342
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 15,866
4. Dates Incurred: 10/31/13 12/24/14

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	Facility	36,213	2013	$ 460,000	1
2					2
3	TOTALS	36,213		$ 460,000	3

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	109		2013		$ 4,140,000	$ 150,545	27.5	$ 150,545	$	$ 181,909	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELECTRIC			2008	10,292	264	39	264		1,738	9
10	LANDSCAPING			2008	5,106	255	20	255		1,638	10
11	DOOR KICKPLATES			2009	1,913	191	10	191		1,067	11
12	ELEVATOR PUMPS			2009	1,462	146	10	146		828	12
13	THERMOSTATIC MIXING VALVE			2009	3,955	101	39	101		540	13
14	DOOR ALARM SYSTEM			2009	1,089	109	10	109		572	14
15	CIRCULATING PUMP-HOT WATER HEATE			2009	1,041	104	10	104		529	15
16	SPACE PAK UNIT MOTOR			2010	1,757	176	10	176		864	16
17	LOCKINVAR			2010	8,942	596	15	596		2,831	17
18	NEW LOCKS			2010	1,417	142	10	142		615	18
19	ELEVATOR ICU CONTROL BOARD			2011	956	96	10	96		359	19
20	EXIT DOOR DEVICE			2011	814	81	10	81		284	20
21	SPRINKLER HEADS			2011	540	54	10	54		185	21
22	BASEMENT TILE FLOORING			2011	964	96	10	96		321	22
23	PATIO DOOR			2011	2,168	217	10	217		705	23
24	DOORS			2012	3,365	337	10	337		1,011	24
25	FREIGHT FOR SMOKE SHELTER			2012	289	29	10	29		87	25
26	2 ROLLER GUIDES FOR ELEVATOR			2012	704	70	10	70		200	26
27	ELEVATOR STARTER CONTACTS			2012	760	76	10	76		215	27
28	A/C IGNITION MODULE			2012	557	56	10	56		154	28
29	ELEVATOR FIRE EQUIPMENT			2012	667	67	10	67		179	29
30	REMODELING SUPPLIES FOR REHAB ROOM			2012	951	24	40	24		64	30
31	RECOVER 40 DOORS			2012	1,025	103	10	103		271	31
32	TEMPERATURE VALVE			2012	599	60	10	60		155	32
33	REMODELING ROOMS 103 & 105-CONTRACT-BOB'S REMODEL			2012	4,850	121	40	121		323	33
34	LIGHT FIXTURES			2012	1,282	32	40	32		85	34
35	ELEVATOR DOOR RESTRICTOR			2012	523	52	10	52		135	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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FIRE EXIT DEVICE FOR DOORS	2012	$ 671	$ 67	10	$ 67	$	$ 173	37
38	3 FIRE SPRINKLERS	2012	1,659	166	10	166		415	38
39	ENERGY EFF LIGHTING FIXTURES	2012	28,345	709	40	709		1,772	39
40	1ST FLOOR FLOORING	2012	12,995	325	40	325		812	40
41	ELEVATOR CONTROL RELAYS	2012	635	64	10	64		154	41
42	FLAT BAR IN NURSES STATION	2012	975	98	40	98		206	42
43	WALL BASE & FLOORING	2012	5,035	126	40	126		305	43
44	HEATING & COOLING PUMP	2012	514	51	10	51		123	44
45	GENERATOR	2012	1,047	105	10	105		245	45
46	FLOORING	2012	368	9	40	9		20	46
47	PAVEMENT SEALER	2012	1,800	90	20	90		203	47
48	FLOORING- FIRST FLOOR	2012	1,432	143	10	143		298	48
49	ELEVATOR GUIDE ROLLERS	2012	545	20	40	20		35	49
50	REMODEL THERAPY ROOM,DINING ROOM, LOBBY	2013	182,347	6,631	27.5	6,631		7,460	50
51	AND FAMILY LOUNGE								51
52	LOBBY:FURNISH AND INSTALLATION OF SCULPTED								52
53	WALLPANEL WITH CUSTOM LOGO								53
54	CORRIDOR:INSTALLATION OF NEW FLOOR AND								54
55	REMOVAL OF OLD FLOOR THROUGHT ENTIRE CORRIDOR								55
56	THERAPY ROOM;WALLCOVERING AND FLOORING OF								56
57	ENTIRE THERAPY ROOM								57
58	DINING ROOM: WALLCOVERING AND NEW FLOORING								58
59	OF ENTIRE DINING ROOM								59
60	FAMILY LOUNGE: INSTALLATION OF NEW WALLS AND								60
61	DOORS, MODIFYING ELECTRIC POWER, INSTALLATION								61
62	OF NEW FLOOR AND NEW CARPET								62
63	OEM PUMP ASSEMBLY	2014	1,346	43	27.5	43		43	63
64	DRYWALL FOR TV'S	2014	916	15	27.5	15		15	64
65	SPRINKLERHEAD	2014	1,120	19	27.5	19		19	65
66	WALLPAPER RESIDENT ROOMS	2014	17,210	78	27.5	78		78	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,456,948	$ 162,959		$ 162,959	$	$ 210,240	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: 01/01/2014 Ending: 12/31/2014

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	$ 376,082	$ 23,932	$ 75,216	$ 51,284	5	$ 256,698	71
72	Current Year Purchases	58,979	9,289	5,898	(3,391)	5	5,898	72
73	Fully Depreciated Assets							73
74	Alloc from AA Mgmt		88	88			88	74
75	TOTALS	$ 435,061	$ 33,309	$ 81,202	$ 47,893		$ 262,684	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	2013 elkhart Coach	2013	$ 53,862	$ 17,236	$ 10,772	$ (6,464)	5	$ 21,544	76
77		2011 Toyotoa Camry	2011	19,418	1,775	3,883	2,108	5	11,973	77
78										78
79										79
80	TOTALS			$ 73,280	$ 19,011	$ 14,655	$ (4,356)		$ 33,517	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)	$ 5,425,289	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 215,279	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 258,816	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 43,537	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 506,441	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: 01/01/2014 Ending: 12/31/2014

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?
   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								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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 244,336	$		$ 244,336	1
2	Licensed Speech and Language Development Therapist		hrs			56,410			56,410	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			271,266			271,266	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				231,067		231,067	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 572,012	$ 231,067		$ 803,079	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: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ (88,400)	$ 115,684	1
2	Cash-Patient Deposits	92,034	92,034	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,582,925	3,582,925	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,914	33,914	6
7	Other Prepaid Expenses	25,804	25,804	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from others,Escrows		570,448	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,646,277	$ 4,420,809	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		460,000	13
14	Buildings, at Historical Cost		4,140,000	14
15	Leasehold Improvements, at Historical Cost	325,695	325,695	15
16	Equipment, at Historical Cost	479,120	479,120	16
17	Accumulated Depreciation (book methods)	(226,704)	(408,613)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		482,342	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(18,000)	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)**	$ 578,111	$ 5,460,544	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,224,388	$ 9,881,353	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,537,619	$ 1,537,619	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	165,960	165,960	28
29	Short-Term Notes Payable	998,325	998,325	29
30	Accrued Salaries Payable	89,183	89,183	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,429	9,429	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	610	610	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to others	294,512	336,574	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,095,638	$ 3,137,700	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	45,803	45,803	39
40	Mortgage Payable		9,280,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 45,803	$ 9,325,803	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,141,441	$ 12,463,503	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,082,947	$ (2,582,150)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,224,388	$ 9,881,353	48

***(See instructions.)**

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 181,323	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	208,440	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 389,763	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	916,684	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	(223,500)	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)**	$ 693,184	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,082,947	24	*

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,599,352	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,599,352	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	432	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 432	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,599,784	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	862,611	31
32	Health Care	3,060,814	32
33	General Administration	1,536,184	33
	B. Capital Expense		
34	Ownership	638,336	34
	C. Ancillary Expense		
35	Special Cost Centers	360,125	35
36	Provider Participation Fee	225,030	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,683,100	40
41	**Income before Income Taxes (line 30 minus line 40)****	916,684	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 916,684	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,515,668	44
45	Private Pay - Net Inpatient Revenue	243,180	45
46	Medicare - Net Inpatient Revenue	2,963,025	46
47	Other-(specify) **Insurance,Managed Care,Hospice,Veterans,B income**	877,479	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,599,352	49

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

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

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

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,160	$ 116,521	$ 53.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,261	29,600	799,690	27.02	3
4	Licensed Practical Nurses	12,375	13,720	343,032	25.00	4
5	CNAs & Orderlies	57,610	64,240	694,349	10.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,693	7,005	73,416	10.48	10
11	Social Service Workers	1,848	2,144	54,493	25.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,471	18,351	208,400	11.36	15
16	Dishwashers					16
17	Maintenance Workers	3,752	4,182	64,578	15.44	17
18	Housekeepers	13,156	13,293	114,764	8.63	18
19	Laundry	4,066	4,070	37,605	9.24	19
20	Administrator	2,272	2,360	135,548	57.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,283	9,205	163,101	17.72	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,731	170,330	$ 2,805,497 *	$ 16.47	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	154	$ 7,225	1-3	35
36	Medical Director		36,300	9-3	36
37	Medical Records Consultant	82	3,920	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		16,640	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	21	840	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	70	2,090	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	327	$ 67,015		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: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Skirven	Administrator		$ 79,867
Igor Rebel	Administrator		55,681
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 135,548

B. Administrative - Other

Description	Amount
Home Office expense	$ 354,346
TOTAL (agree to Schedule V, line 17, col. 3)	$ 354,346
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Rehab Management Systems	Reimbursement consulting	$ 24,000
Mendel Schneider & Associates	Accounting	12,000
Cooper Appraisal	Appraisal	5,500
JLH Surveying	Survey	1,000
Meyer Magence	Legal	4,525
One Beacon	Legal	5,000
Franks Gerkin	Legal	820
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 52,845

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,179
Unemployment Compensation Insurance	58,259
FICA Taxes	214,621
Employee Health Insurance	117,168
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 463,227

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	20,787
Health Care Worker Background Check	
(Indicate # of checks performed 50)	500
Patient Background Checks 100	1,000
Illinois Council on long term Care	11,576
Lake county	841
City of Waukegan	4,800
Sec of State	351
Misc Licenses	1,077
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,932

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Allocated from AA Management	7,490
Relias Learning	6,830
Misc seminars	1,829
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,149

**See instructions.

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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. **Illinois Council On Long Term Care $11576**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **65,500** Line **10**

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

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

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **225,030**
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? **N/A**

(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. $ **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. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **no**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **no**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.