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.

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

I. IDPH License ID Number: 0049809

Facility Name: Pavilion Of Waukegan

Address: 2217 S Washington (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 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 01/01/2018 to 12/31/2018 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 CPA & Associates
4051 Old Orchard Rd Skokie, Illinois 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: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1 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	2,300	250	6,651	9,201	8
9	SNF/PED					9
10	ICF	21,593	2,261		23,854	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,893	2,511	6,651	33,055	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.08%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 5,379

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	254,491	17,190	7,200	278,881		278,881		278,881			1
2	Food Purchase		185,189		185,189		185,189		185,189			2
3	Housekeeping	180,237	29,197	26,480	235,914		235,914		235,914			3
4	Laundry	50,313	15,339		65,652		65,652		65,652			4
5	Heat and Other Utilities			78,774	78,774		78,774		78,774			5
6	Maintenance	44,556		58,460	103,016		103,016	68	103,084			6
7	Other (specify):*											7
8	TOTAL General Services	529,597	246,915	170,914	947,426		947,426	68	947,494			8
	B. Health Care and Programs											
9	Medical Director			31,000	31,000		31,000		31,000			9
10	Nursing and Medical Records	2,335,410	348,457	13,163	2,697,030		2,697,030		2,697,030			10
10a	Therapy											10a
11	Activities	102,689	8,297	1,772	112,758		112,758		112,758			11
12	Social Services	52,618			52,618		52,618		52,618			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,490,717	356,754	45,935	2,893,406		2,893,406		2,893,406			16
	C. General Administration											
17	Administrative	196,672		353,640	550,312		550,312		550,312			17
18	Directors Fees											18
19	Professional Services			66,421	66,421		66,421	8,500	74,921			19
20	Dues, Fees, Subscriptions & Promotions			68,250	68,250		68,250	(43,306)	24,944			20
21	Clerical & General Office Expenses	264,074	69,814	295,693	629,581		629,581	(25,013)	604,568			21
22	Employee Benefits & Payroll Taxes			575,352	575,352		575,352		575,352			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,379	13,379		13,379		13,379			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			180,892	180,892		180,892	12,132	193,024			26
27	Other (specify):*											27
28	TOTAL General Administration	460,746	69,814	1,553,627	2,084,187		2,084,187	(47,687)	2,036,500			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,481,060	673,483	1,770,476	5,925,019		5,925,019	(47,619)	5,877,400			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: 01/01/2018 Ending: 12/31/2018

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			86,141	86,141		86,141	113,343	199,484			30
31	Amortization of Pre-Op. & Org.							98,236	98,236			31
32	Interest			61,963	61,963		61,963	322,308	384,271			32
33	Real Estate Taxes							84,489	84,489			33
34	Rent-Facility & Grounds			745,177	745,177		745,177	(745,177)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MIP							59,225	59,225			36
37	TOTAL Ownership			893,281	893,281		893,281	(67,576)	825,705			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			223,337	223,337		223,337		223,337			42
43	Other (specify):* Bad Debt			215,313	215,313		215,313	(215,313)				43
44	TOTAL Special Cost Centers			438,650	438,650		438,650	(215,313)	223,337			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,481,060	673,483	3,102,407	7,256,950		7,256,950	(330,508)	6,926,442			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: 01/01/2018 Ending: 12/31/2018

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	(37,202)	30		9
10	Interest and Other Investment Income	(5,218)	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	(9,034)	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	(215,313)	43		24
25	Fund Raising, Advertising and Promotional	(43,306)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(15,979)	21		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)**	$ (326,052)		$	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)	(4,456)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (4,456)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (330,508)		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: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pavilion Of Waukegan # 0049809 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 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	68	0	0	0	0	0	0	0	0	0	68	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	68	0	0	0	0	0	0	0	0	0	68	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	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,500	0	0	0	0	0	0	0	0	0	8,500	19
20	Fees, Subscriptions & Promotions	(43,306)	0	0	0	0	0	0	0	0	0	0	(43,306)	20
21	Clerical & General Office Expenses	(25,013)	0	0	0	0	0	0	0	0	0	0	(25,013)	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	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	12,132	0	0	0	0	0	0	0	0	0	12,132	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(68,319)	20,632	0	0	0	0	0	0	0	0	0	(47,687)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(68,319)	20,700	0	0	0	0	0	0	0	0	0	(47,619)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pavilion Of Waukegan # 0049809 **Report Period Beginning:** 01/01/2018 **Ending:** 12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(37,202)	150,545	0	0	0	0	0	0	0	0	0	113,343	30
31	Amortization of Pre-Op. & Org.	0	98,236	0	0	0	0	0	0	0	0	0	98,236	31
32	Interest	(5,218)	327,526	0	0	0	0	0	0	0	0	0	322,308	32
33	Real Estate Taxes	0	84,489	0	0	0	0	0	0	0	0	0	84,489	33
34	Rent-Facility & Grounds	0	(745,177)	0	0	0	0	0	0	0	0	0	(745,177)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	59,225	0	0	0	0	0	0	0	0	0	59,225	36
37	**TOTAL Ownership**	(42,420)	(25,156)	0	0	0	0	0	0	0	0	0	(67,576)	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):*	(215,313)	0	0	0	0	0	0	0	0	0	0	(215,313)	43
44	**TOTAL Special Cost Centers**	(215,313)	0	0	0	0	0	0	0	0	0	0	(215,313)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(326,052)	(4,456)	0	0	0	0	0	0	0	0	0	(330,508)	45

Facility Name & ID Number Pavilion Of Waukegan # 0049809 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			

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	$ 745,177	Pavilion of Waukegan Realty	100.00%	$	$ (745,177)	1
2	V	32	Interest		Pavilion of Waukegan Realty		327,526	327,526	2
3	V	33	Real Estate Taxes		Pavilion of Waukegan Realty		84,489	84,489	3
4	V	30	Depreciation		Pavilion of Waukegan Realty		150,545	150,545	4
5	V	31	Amortization		Pavilion of Waukegan Realty		98,236	98,236	5
6	V	36	MIP Insurance		Pavilion of Waukegan Realty		59,225	59,225	6
7	V	26	Insurance		Pavilion of Waukegan Realty		12,132	12,132	7
8	V	19	Professional Fees		Pavilion of Waukegan Realty		8,500	8,500	8
9	V	6	Repairs		Pavilion of Waukegan Realty		68	68	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 745,177			$ 740,721	$ * (4,456)	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: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

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

Facility Name & ID Number Pavilion Of Waukegan # 0049809 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1	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	Mgmt	75.00	640,650	20	40.00	Mgmt Fee	$ 353,640	17-3	1
2	Joseph Brandman	Manager	Mgmt	25.00	147,691	20	40.00				2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 353,640		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: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Pavilion Of Waukegan # 0049809 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Capital One		X	Mortgage	$39,013.23	12/22/16	$ 9,323,100	$ 9,058,563	01/01/52	3.5900	$ 327,526	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Working Capital				1,192,748		5.0000	61,963	6
7												7
8												8
9	TOTAL Facility Related				$39,013.23		$ 9,323,100	$ 10,251,311			$ 389,489	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,218)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,218)	14
15	TOTALS (line 9+line14)						$ 9,323,100	$ 10,251,311			$ 384,271	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: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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.)	$	84,489	2
3. Under or (over) accrual (line 2 minus line 1).	$	84,489	3
4. Real Estate Tax accrual used for 2018 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.	$	84,489	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	85,099	8
2014	75,944	9
2015	89,800	10
2016	91,980	11
2017	84,489	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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.

2017 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 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20-300-044	Facility	$ 79,214.78	$ 79,214.78
2.	08-20-311-001	Facility	$ 5,274.71	$ 5,274.71
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 84,489.49	$ 84,489.49

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Pavilion Of Waukegan # 0049809 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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: 618,916
2. Number of Years Over Which it is Being Amortized: 35
3. Current Period Amortization: 98,236
4. Dates Incurred: 12/22/16

Nature of Costs: HUD Closing 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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 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	$	$ 784,089	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Electric			2008	10,292	374	39	264	(110)	2,794	9
10	Landscaping			2008	5,106	151	20	255	104	2,658	10
11	Door Kickplates			2009	1,913	191	10	191		1,831	11
12	Elevator Pumps			2009	1,462	146	10	146		1,412	12
13	Thermostatic Mixing Valve			2009	3,955	144	39	101	(43)	944	13
14	Door Alarm System			2009	1,089	109	10	109		1,008	14
15	Circulating Pump-Hot Water Heater			2009	1,041	104	10	104		945	15
16	Space Pak Unit Motor			2010	1,757	176	10	176		1,568	16
17	Lockinvar			2010	8,942	596	15	596		5,215	17
18	New Locks			2010	1,417	51	10	142	91	1,183	18
19	Elevator ICU Control Board			2011	956	96	10	96		743	19
20	Exit Door Device			2011	814	81	10	81		608	20
21	Sprinkler Heads			2011	540	54	10	54		401	21
22	Basement Tile Flooring			2011	964	96	10	96		705	22
23	Patio Door			2011	2,168	217	10	217		1,573	23
24	Doors			2012	3,365	122	10	337	215	2,359	24
25	Freight for Smoke Shelter			2012	289	13	10	29	16	203	25
26	2 Roller Guides for Elevator			2012	704	25	10	70	45	480	26
27	Elevator Starter Contacts			2012	760	28	10	76	48	519	27
28	A/C Ignition Module			2012	557	20	10	56	36	378	28
29	Elevator Fire Equipment			2012	667	24	10	67	43	447	29
30	Remodeling Supplies For Rehab Room			2012	951	35	40	24	(11)	160	30
31	Recover 40 Doors			2012	1,025	37	10	103	66	683	31
32	Temperature Valve			2012	599	33	10	60	27	395	32
33	Remodeling Rooms 103 & 105-Contract-Bob's Remodel			2012	4,850	176	40	121	(55)	807	33
34	Light Fixtures			2012	1,282	47	40	32	(15)	213	34
35	Elevator Door Restrictor			2012	523	33	10	52	19	343	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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 24	10	$ 67	$ 43	$ 441	37
38	3 Fire Sprinklers	2012	1,659	60	10	166	106	1,079	38
39	Energy Eff Lighting Fixtures	2012	28,345	1,031	40	709	(322)	4,608	39
40	1st Floor Flooring	2012	12,995	795	40	325	(470)	2,112	40
41	Elevator Control Relays	2012	635	23	10	64	41	410	41
42	Flat Bar in Nurses Station	2012	975	35	10	98	63	598	42
43	Wall Base & Flooring	2012	5,035	173	40	126	(47)	809	43
44	Heating & Cooling Pump	2012	514	31	10	51	20	327	44
45	Generator	2012	1,047	64	10	105	41	665	45
46	Flooring	2012	368	13	40	9	(4)	56	46
47	Pavement Sealer	2012	1,800	62	20	90	28	563	47
48	Flooring First Floor	2012	1,432	98	10	143	45	870	48
49	Elevator Guide Rollers	2012	545	20	27.5	20		115	49
50	Remoder Therapy Room,Dining Room,Lobby	2012	182,347	6,631	27.5	6,631		33,984	50
51	and family Lounge								51
52	Lobby:Furnish and Installation of Sculpted								52
53	Wallpaper With Custom Logo								53
54	Corridor:Installation of New Floor and								54
55	Removal of Old Floor Thru Out 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	49	27.5	49		239	63
64	Drywall for TVs	2014	916	33	27.5	33		147	64
65	Sprinklehead	2014	1,120	41	27.5	41		183	65
66	Wallpaper Resident Rooms	2014	17,210	626	27.5	626		2,582	66
67	Sprinklers	2015	1,700	62	27.5	62		245	67
68	Rebuild Weil	2015	5,298	193	27.5	193		732	68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,463,946	$ 163,788		$ 163,808	$ 20	$ 865,429	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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,463,946	$ 163,788		$ 163,808	$ 20	$ 865,429	1
2	Call Lights	2015	2,895	105	27.5	105		398	2
3	New Sign	2015	1,656	127	15	157	30	554	3
4	Generator Valve	2015	2,195	80	27.5	80		257	4
5	Replace Elevator	2015	5,464	199	27.5	199		605	5
6	Remodel Resident Bathrooms and Analysis Room	2015	62,373	2,268	27.5	2,268		8,397	6
7	Removed and Replaced all Drywall in Mensroom & Kitchen Area								7
8	Demolition Of Existing Drywall Walls & Ceiling,Demolition of Existing Entry Closets								8
9	Build New Steel Stud Framing Around New Bathroom and								9
10	Enlarged All Area,Opened Up Bathroom Concrete Floors and								10
11	Relocated All Underground and Above Ground Waste and Water Lines								11
12	Purchased and Installed 3/1/C Heat Pump Units								12
13	Replace Generator	2016	56,495	3,766	15	3,766		9,415	13
14	New Lighted Sign	2016	13,740	916	15	916		2,290	14
15	Bathroom Exhaust	2016	7,800	520	15	520		1,300	15
16	Reception Area Enlarged by Demolishing Adm Office	2016	41,036	2,736	15	2,736		6,673	16
17	Install New Work Area,Lighting,Fish Tank and Signage								17
18	in Reception Area								18
19	Installed Partition Glass with Sandblasted Horizontal Frosted Stripe								19
20	Remodel 2 Guest Bathrooms and Bathroom in 102 & 116	2017	13,750	653	15	917	264	1,375	20
21	Remodel Sprinkler Room	2017	3,580	170	15	239	69	358	21
22	Repair Roof Flashing & Vents	2017	2,190	104	15	146	42	219	22
23	Replace generator	2017	27,150	1,203	15	1,810	607	2,715	23
24	Replace 43 Handles and Locks	2017	7,841	372	15	523	151	784	24
25	Replace Boiler	2017	8,948	425	15	597	172	895	25
26	New Ejector Pump	2017	21,890	1,040	15	1,459	419	2,189	26
27	New Fire Panel	2017	7,800	371	15	520	149	780	27
28	New LED Lights	2017	29,387	1,396	15	1,959	563	2,939	28
29	New Condensor unit	2017	7,300	347	15	487	140	730	29
30	New Sign	2017	16,482	783	15	1,099	316	1,648	30
31	New Heat Exchange First Floor	2017	2,540	121	15	169	48	254	31
32	Drain Medic	2017	1,112	53	15	74	21	111	32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,807,570	$ 181,543		$ 184,554	$ 3,011	$ 910,315	34

**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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,807,570	$ 181,543		$ 184,554	$ 3,011	$ 910,315	1
2	Built New Office,Demolish old Structure	2018	50,266	50,266	15	1,676	(48,590)	1,676	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,857,836	$ 231,809		$ 186,230	$ (45,579)	$ 911,991	34

**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: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 502,716	$	$ 13,254	$ 13,254		$ 489,462	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 502,716	$	$ 13,254	$ 13,254		$ 489,462	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	$ 3,102	$	$ (3,102)		$ 53,862	76
77	Facility	2011 Toyota Camry	2011	19,418	1,775		(1,775)		19,418	77
78										78
79										79
80	TOTALS			$ 73,280	$ 4,877	$	$ (4,877)		$ 73,280	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)	$ 5,893,832	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 236,686	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 199,484	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (37,202)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,474,733	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: 01/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								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.	/2019	$
13.	/2020	$
14.	/2021	$

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: 01/01/2018 Ending: 12/31/2018

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.

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	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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							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			$		$	$		$	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: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,528	$ 68,063	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,703,979	1,703,979	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,476	72,476	6
7	Other Prepaid Expenses	37,920	37,920	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due Related Parties/Escrows	1,573,309	2,642,644	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,397,212	$ 4,525,082	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	726,582	726,582	15
16	Equipment, at Historical Cost	546,774	546,774	16
17	Accumulated Depreciation (book methods)	(610,474)	(1,390,594)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		618,916	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(313,402)	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)**	$ 662,882	$ 4,788,276	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,060,094	$ 9,313,358	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,157,151	$ 1,157,151	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	136,002	136,002	28
29	Short-Term Notes Payable	1,192,748	1,192,748	29
30	Accrued Salaries Payable	152,988	152,988	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,614	13,614	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	7,209	34,309	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,659,712	$ 2,686,812	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,058,563	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)**	$	$ 9,058,563	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,659,712	$ 11,745,375	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,400,382	$ (2,432,017)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,060,094	$ 9,313,358	48

*(See instructions.)

Facility Name & ID Number Pavilion Of Waukegan # 0049809 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,218,454	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,218,454	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	536,928	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	(355,000)	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)**	$ 181,928	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)**	$ 1,400,382	24 *

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

Facility Name & ID Number Pavilion Of Waukegan # 0049809 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,788,660	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,788,660	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***	5,218	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,218	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)**	$ 7,793,878	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	947,426	31
32	Health Care	2,893,406	32
33	General Administration	2,084,187	33
	B. Capital Expense		
34	Ownership	893,281	34
	C. Ancillary Expense		
35	Special Cost Centers	215,313	35
36	Provider Participation Fee	223,337	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,256,950	40
41	**Income before Income Taxes (line 30 minus line 40)****	536,928	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 536,928	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,666,218	44
45	Private Pay - Net Inpatient Revenue	495,365	45
46	Medicare - Net Inpatient Revenue	2,352,080	46
47	Other-(specify) Veterans	274,997	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,788,660	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 Bas 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: 01/01/2018 Ending: 12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,745	4,159	$ 208,258	$ 50.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,721	14,986	462,271	30.85	3
4	Licensed Practical Nurses	20,145	24,733	505,806	20.45	4
5	CNAs & Orderlies	62,369	66,445	1,159,075	17.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,888	2,080	38,587	18.55	9
10	Activity Assistants	5,167	5,167	64,102	12.41	10
11	Social Service Workers	1,912	2,120	52,618	24.82	11
12	Dietician					12
13	Food Service Supervisor	3,920	4,454	84,062	18.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,721	15,627	170,429	10.91	15
16	Dishwashers					16
17	Maintenance Workers	1,880	2,080	44,556	21.42	17
18	Housekeepers			180,237		18
19	Laundry	4,307	4,504	50,313	11.17	19
20	Administrator	3,104	3,144	196,672	62.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,939	12,779	264,074	20.66	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)	148,818	162,278	$ 3,481,060 *	$ 21.45	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	150	$ 7,200	1-3	35
36	Medical Director		31,000	9-3	36
37	Medical Records Consultant	100	4,800	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	5,928	9-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	60	2,435	9-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	35	1,772	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	441	$ 53,135		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: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Igor Rebel	Administrator	0	$ 89,666
Akiva Brandman	Administrator	0	79,682
Yehuda Hollander	Asst Adminis	0	27,324
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 196,672

B. Administrative - Other

Description	Amount
Aaron Topper-Mgmt Fee	$ 353,640
TOTAL (agree to Schedule V, line 17, col. 3)	$ 353,640
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider CPA	Accounting	$ 14,000
Rehab Mgmt Systems	Reimbursement Consulting	24,000
Integra Scripts	RX Consulting	3,838
Sher LLP	Legal	315
Skidelsky & Assoc	Legal	2,866
Meyer Magence	Legal	150
Quarles & Brady	Legal	21,252
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 66,421

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,314
Unemployment Compensation Insurance	20,059
FICA Taxes	266,350
Employee Health Insurance	223,629
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 575,352

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Advertising	43,306
Dues-ICLTC	20,437
Misc Inspections	2,517
Less: Public Relations Expense	( )
Non-allowable advertising	(43,306)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,944

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
HIN Seminars	856
Relias	5,662
Various	6,861
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,379

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Pavilion Of Waukegan # 0049809 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Il Council Long Term Care 20437**

(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? **15**

(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. $ **223,337**
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? 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? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees