		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: **Telephone Number:** ( )
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 01/01/2020 to 12/31/2020 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) 4/28/2021
(Type or Print Name) Aaron Topper
(Title) CEO

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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: 01/01/2020 Ending: 12/31/2020

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	112	Skilled (SNF)	112	40,992	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	112	TOTALS	112	40,992	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	6,148	2,062	24,219	32,429	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,148	2,062	24,219	32,429	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.11%

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 12/01/2017

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 12/01/2017 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 112 and days of care provided 4,221

Medicare Intermediary NGS

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: 01/01/2020 Ending: 12/31/2020

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	277,222	30,343	23,025	330,590		330,590		330,590			1
2	Food Purchase		163,478		163,478		163,478		163,478			2
3	Housekeeping	139,856	37,603	5,736	183,195		183,195		183,195			3
4	Laundry	80,203	16,662		96,865		96,865		96,865			4
5	Heat and Other Utilities											5
6	Maintenance	42,848	17,536	161,846	222,230		222,230		222,230			6
7	Other (specify):*											7
8	**TOTAL General Services**	540,129	265,622	190,607	996,358		996,358		996,358			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	2,582,499	205,243	301,070	3,088,812		3,088,812		3,088,812			10
10a	Therapy			615,366	615,366		615,366		615,366			10a
11	Activities	100,710	4,816	2,312	107,838		107,838		107,838			11
12	Social Services	55,224			55,224		55,224		55,224			12
13	CNA Training											13
14	Program Transportation			11,813	11,813		11,813		11,813			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,738,433	210,059	969,561	3,918,053		3,918,053		3,918,053			16
	C. General Administration											
17	Administrative	104,239		386,206	490,445		490,445		490,445			17
18	Directors Fees											18
19	Professional Services			34,524	34,524		34,524	(20,424)	14,100			19
20	Dues, Fees, Subscriptions & Promotions			35,342	35,342		35,342	(15,745)	19,597			20
21	Clerical & General Office Expenses	240,305	3,580	308,416	552,301		552,301	(24,621)	527,680			21
22	Employee Benefits & Payroll Taxes			649,037	649,037		649,037		649,037			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,226	8,226		8,226		8,226			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			163,692	163,692		163,692	15,898	179,590			26
27	Other (specify):*											27
28	**TOTAL General Administration**	344,544	3,580	1,585,443	1,933,567		1,933,567	(44,892)	1,888,675			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,623,106	479,261	2,745,611	6,847,978		6,847,978	(44,892)	6,803,086			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: 01/01/2020 Ending: 12/31/2020

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			48,246	48,246		48,246	196,391	244,637			30
31	Amortization of Pre-Op. & Org.			7,417	7,417		7,417	125,086	132,503			31
32	Interest			36,873	36,873		36,873	535,476	572,349			32
33	Real Estate Taxes							78,022	78,022			33
34	Rent-Facility & Grounds			663,191	663,191		663,191	(244,170)	419,021			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							54,573	54,573			36
37	**TOTAL Ownership**			755,727	755,727		755,727	745,378	1,501,105			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			192,854	192,854		192,854		192,854			42
43	Other (specify):* **Bad Debt**			105,982	105,982		105,982	(105,982)				43
44	**TOTAL Special Cost Centers**			298,836	298,836		298,836	(105,982)	192,854			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,623,106	479,261	3,800,174	7,902,541		7,902,541	594,504	8,497,045			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: 01/01/2020 Ending: 12/31/2020

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 Reference	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	(13,582)	30		9
10	Interest and Other Investment Income	(606)	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	(28,924)	19		17
18	Fines and Penalties	(1,546)	21		18
19	Entertainment				19
20	Contributions	(23,075)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(105,982)	43		24
25	Fund Raising, Advertising and Promotional	(15,745)	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)**	$ (189,460)		$	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)	391,982	34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 391,982		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 202,522		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: 01/01/2020

Ending: 12/31/2020

	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: 01/01/2020 Ending: 12/31/2020

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	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	(28,924)	8,500	0	0	0	0	0	0	0	0	0	(20,424)	19
20	Fees, Subscriptions & Promotions	(15,745)	0	0	0	0	0	0	0	0	0	0	(15,745)	20
21	Clerical & General Office Expenses	(24,621)	0	0	0	0	0	0	0	0	0	0	(24,621)	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	15,898	0	0	0	0	0	0	0	0	0	15,898	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(69,290)	24,398	0	0	0	0	0	0	0	0	0	(44,892)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(69,290)	24,398	0	0	0	0	0	0	0	0	0	(44,892)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pavilion of Waukegan # 0049809 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

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	(13,582)	209,973	0	0	0	0	0	0	0	0	0	196,391	30
31	Amortization of Pre-Op. & Org.	0	125,086	0	0	0	0	0	0	0	0	0	125,086	31
32	Interest	(606)	536,082	0	0	0	0	0	0	0	0	0	535,476	32
33	Real Estate Taxes	0	78,022	0	0	0	0	0	0	0	0	0	78,022	33
34	Rent-Facility & Grounds	391,982	(636,152)	0	0	0	0	0	0	0	0	0	(244,170)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	54,573	0	0	0	0	0	0	0	0	0	54,573	36
37	**TOTAL Ownership**	377,794	367,584	0	0	0	0	0	0	0	0	0	745,378	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):*	(105,982)	0	0	0	0	0	0	0	0	0	0	(105,982)	43
44	**TOTAL Special Cost Centers**	(105,982)	0	0	0	0	0	0	0	0	0	0	(105,982)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	202,522	391,982	0	0	0	0	0	0	0	0	0	594,504	45

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Waukegan	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. ☐ 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	$ 636,152	Pavilion of Waukegan	100.00%	$	$ (636,152)	1
2	V	32	Interest		Pavilion of Waukegan		536,082	536,082	2
3	V	33	Real Estate Taxes		Pavilion of Waukegan		78,022	78,022	3
4	V	30	Depreciation		Pavilion of Waukegan		209,973	209,973	4
5	V	31	Amortization		Pavilion of Waukegan		125,086	125,086	5
6	V	36	MIP Insurance		Pavilion of Waukegan		54,573	54,573	6
7	V	26	Insurance		Pavilion of Waukegan		15,898	15,898	7
8	V	19	Professional Fees		Pavilion of Waukegan		8,500	8,500	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 636,152			$ 1,028,134	$ * 391,982	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: 01/01/2020 Ending: 12/31/2020

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: 01/01/2020 Ending: 12/31/2020

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	0.75	546,083	20	40.00	Mgmt	$ 386,206	17-3	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	$ 386,206		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: 01/01/2020 Ending: 2/31/2020

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: 01/01/2020 Ending: 12/31/2020

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	Walker & Dunlop		x	Mortgage	$36,600.00	9/30/2020	$ 9,323,100	$ 9,117,792	1/1/52	3.5900	$ 282,133	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi			Line of credit				527,010	1/31/21	5.0000	36,873	6
7												7
8												8
9	TOTAL Facility Related				$36,600.00		$ 9,323,100	$ 9,644,802			$ 319,006	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,323,100	$ 9,644,802			$ 319,006	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: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	77,841	2
3. Under or (over) accrual (line 2 minus line 1).	$	77,841	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	77,841	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	89,800	8
	2016	91,980	9
	2017	84,489	10
	2018	77,663	11
	2019	77,841	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20-300-044	Facility	$ 75,996.20	$ 75,996.20
2.	08-20-311-001	Facility	$ 1,844.62	$ 1,844.62
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 77,840.82	$ 77,840.82

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,160 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? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	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: 01/01/2020 Ending: 12/31/2020

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	$ 150,546	27.5	$ 150,546	$	$ 1,085,181	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Electric			2008	10,292	368	39	264	(104)	3,322	9
10	Landscaping			2008	5,106	511	20	255	(256)	3,168	10
11	Door Kickplates			2009	1,913		10			1,913	11
12	Elevator Pumps			2009	1,462		10	146	146	1,462	12
13	Thermostat Mixing Valve			2009	3,955	144	39	101	(43)	1,146	13
14	Door Alarm System			2009	1,089		10			1,089	14
15	Ciculating Pump- Hot water heater			2009	1,041		10			1,041	15
16	Space pack unit motor			2010	1,757	13	10	13		1,757	16
17	Lockinvar			2010	8,942	596	15	596	0	6,407	17
18	New Locks			2010	1,417	51	10	142	91	1,417	18
19	Elevator ICU Control Board			2011	956	96	10	96	(0)	935	19
20	Exit Door Device			2011	814	81	10	81	0	770	20
21	Sprinkler Heads			2011	540	54	10	54		509	21
22	Basement Tile Flooring			2011	964	96	10	96	0	897	22
23	Patio Door			2011	2,168	217	10	217	(0)	2,007	23
24	Doors			2012	3,365	120	10	337	217	3,033	24
25	Freight for Smoke Shelter			2012	289	29	10	29	(0)	261	25
26	Roller Guides for Elevator			2012	704	70	10	70	0	620	26
27	Elevator Starter Contacts			2012	760	76	10	76		671	27
28	A/C Ignition Module			2012	557	56	10	56	(0)	490	28
29	Elevator Fire Equipment			2012	667	67	10	67	(0)	581	29
30	Remodeling Supplies for Rehab Room			2012	951	24	40	24	(0)	208	30
31	Recover 40 Doors			2012	1,025	103	10	103	(1)	889	31
32	Temperature Valve			2012	599	60	10	60	(0)	515	32
33	Remodeling Rooms 103 & 105			2012	4,850	173	40	121	(52)	1,049	33
34	Light Fixtures			2012	1,282	32	40	32	0	277	34
35	Elevator Door Restrictor			2012	523	52	10	52	0	447	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: 01/01/2020 Ending: 12/31/2020

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	$ 575	37
38	3 Fire Sprinklers	2012	1,659	59	10	166	107	1,411	38
39	Energy Eff Lighting Fixtures	2012	28,345	1,012	40	709	(303)	6,026	39
40	1st Floor Flooring	2012	12,995	5,198	40	325	(4,873)	2,762	40
41	Elevator Control Relays	2012	635	23	10	64	41	538	41
42	Flat Bar in Nurses Station	2012	975	35	10	98	63	794	42
43	Wall Base & Flooring	2012	5,035	277	40	126	(151)	1,061	43
44	Heating & Cooling Pump	2012	514	206	10	51	(155)	429	44
45	Generator	2012	1,047	105	10	105	(0)	875	45
46	Flooring	2012	368	9	40	9	0	74	46
47	Pavement Sealer	2012	1,800	90	20	90		1,890	47
48	Flooring First Floor	2012	1,432	143	10	143	0	1,156	48
49	Elevator Guide Rollers	2012	545	20	27.5	20	(0)	155	49
50	Remodel Therapy Room, Dining Room, Lobby	2012	182,347	6,631	27.5	6,631	(0)	47,246	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 Throughout 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	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	(0)	337	63
64	Drywall for TVs	2014	916	33	27.5	33	0	213	64
65	Sprinklehead	2014	1,120	41	27.5	41	(0)	265	65
66	Wallpaper Residents Rooms	2014	17,210	626	27.5	626	(0)	3,834	66
67	Sprinklers	2015	1,700	62	27.5	62	(0)	369	67
68	Rebuild Weil	2015	5,298	193	27.5	193	(0)	1,118	68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,463,946	$ 168,471		$ 163,240	$ (5,231)	$ 1,193,190	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: 01/01/2020 Ending: 12/31/2020

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	$ 168,471		$ 163,240	$ (5,231)	$ 1,193,190	1
2	Call Lights	2015	2,895	103	27.5	105	2	608	2
3	New Sign	2015	1,656		15	110	110	821	3
4	Generator Valve	2015	2,195	78	27.5	80	2	417	4
5	Replace Elevator	2015	5,464	195	27.5	199	4	1,003	5
6	Remodel Resident Bathrooms and Analysis Room	2015	62,373	2,227	27.5	2,268	41	12,933	6
7	Removed and Replaced all Drywall in Mensroom & Kitchen Area								7
8	Demolition of Existing Drywall & Ceilings, 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		16,947	13
14	New Lighted Sign	2016	13,740	916	15	916		4,122	14
15	Bathroom Exhaust	2016	7,800	520	15	520		2,340	15
16	Reception Area Enlarged by Demolishing Adm Office	2016	41,036	2,736	15	2,736		12,145	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	917	15	917		3,209	20
21	Remodel Sprinkler Room	2017	3,580	239	15	239		836	21
22	Repair Roof Flashing & Vents	2017	2,190	146	15	146		511	22
23	Replace Generator	2017	27,150	1,810	15	1,810		6,335	23
24	Replace 43 Handles & Locks	2017	7,841	523	15	523		1,830	24
25	Replace Boiler	2017	8,948	597	15	597		2,089	25
26	New Ejector Pump	2017	21,890	1,459	15	1,459		5,107	26
27	New Fire Panel	2017	7,800	520	15	520		1,820	27
28	New LED Lights	2017	29,387	1,959	15	1,959		6,857	28
29	New Conductor Unit	2017	7,300	487	15	487		1,704	29
30	New Sign	2017	16,482	1,099	15	1,099		3,846	30
31	New Heat Exchange First Floor	2017	2,540	169	15	169		592	31
32	Drain Medic	2017	1,112	74	15	74		259	32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,807,570	$ 189,010		$ 183,938	$ (5,072)	$ 1,279,521	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: 01/01/2020 Ending: 12/31/2020

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	$ 189,010		$ 183,938	$ (5,072)	$ 1,279,521	1
2	Built New Office, Demolish Old Structure	2018	50,266	5,026	15	3,351	(1,675)	8,378	2
3	Pump Bearings	2019	3,360	336	15	224	(112)	336	3
4	Sewer	2019	1,456	146	15	97	(49)	146	4
5	Alarm	2019	5,123		15	342	342	513	5
6	Repair PVC Drain,Install ceramic Tile,Rodding Shower Drains	2019	2,420	242	15	161	(81)	242	6
7	Excavate Inside Laundry to Install Sump Pump	2019	4,610	461	15	307	(154)	461	7
8	Second Floor Remodeling	2020	54,977	916	20	916		916	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)		$ 4,929,782	$ 196,137		$ 189,336	$ (6,801)	$ 1,290,513	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: 01/01/2020 Ending: 12/31/2020

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	$ 506,643	$ 99,969	$ 54,939	$ (45,030)	5	$ 287,732	71
72	Current Year Purchases	6,760	362	362		5	362	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 513,403	$ 100,331	$ 55,301	$ (45,030)		$ 288,094	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	$	$	$		$ 53,862	76
77	Facility	2011 Toyota Camry	2011	19,418					19,418	77
78										78
79										79
80	TOTALS			$ 73,280	$	$	$		$ 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)	$ 5,976,465	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 296,468	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 244,637	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (51,831)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,651,887	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: 01/01/2020 Ending: 12/31/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: 01/01/2020 Ending: 12/31/2020

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: 01/01/2020 Ending: 12/31/2020

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:** 01/01/2020 **Ending:** 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2020 **(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	$ 743,703	$ 838,179	1
2	Cash-Patient Deposits	75,721	75,721	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 174,964)	1,613,395	1,613,395	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,759	56,759	6
7	Other Prepaid Expenses	6,874	6,874	7
8	Accounts Receivable (owners or related parties)	1,586,032	1,586,032	8
9	Other(specify): various	26,819	1,432,330	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,109,303	$ 5,609,290	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		4,241,822	14
15	Leasehold Improvements, at Historical Cost	602,165	602,165	15
16	Equipment, at Historical Cost	567,265	567,265	16
17	Accumulated Depreciation (book methods)	(634,552)	(1,781,503)	17
18	Deferred Charges	39,380	39,380	18
19	Organization & Pre-Operating Costs		683,447	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,417)	(626,879)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Security deposit	100,000	100,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 666,841	$ 4,285,697	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,776,144	$ 9,894,987	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 405,120	$ 405,120	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	75,721	75,721	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	216,962	216,962	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,683	19,683	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Line of credit	527,010	527,010	36
37	Loans/Advanced/Accrued expense	1,785,088	1,927,420	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,029,584	$ 3,171,916	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,117,792	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)**	$	$ 9,117,792	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,029,584	$ 12,289,708	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,746,560	$ (2,394,721)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,776,144	$ 9,894,987	48

***(See instructions.)**

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,762,246	1
2	Restatements (describe):		2
3	balance sheet reconciliation	(163,648)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,598,598	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,317,285	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	(1,169,323)	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)**	$ 147,962	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)**	$ 1,746,560	24 *

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

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 9,219,220	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,219,220	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***	606	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 606	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)**	$ 9,219,826	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	996,358	31
32	Health Care	3,918,053	32
33	General Administration	1,934,713	33
	B. Capital Expense		
34	Ownership	754,581	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	192,854	36
	D. Other Expenses (specify):		
37	Bad Debt	105,982	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,902,541	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,317,285	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,317,285	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

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

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

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

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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	1,968	2,088	$ 115,286	$ 55.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,111	22,978	824,793	35.89	3
4	Licensed Practical Nurses	13,182	14,309	427,374	29.87	4
5	CNAs & Orderlies	67,004	70,143	1,179,084	16.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,984	2,080	41,395	19.90	9
10	Activity Assistants	6,103	6,127	59,315	9.68	10
11	Social Service Workers	1,936	2,080	55,224	26.55	11
12	Dietician	7,708	8,202	136,833	16.68	12
13	Food Service Supervisor					13
14	Head Cook	10,246	10,946	140,389	12.83	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,864	2,080	42,848	20.60	17
18	Housekeepers	11,430	11,928	139,856	11.73	18
19	Laundry	6,598	6,879	80,203	11.66	19
20	Administrator	2,064	2,088	104,239	49.92	20
21	Assistant Administrator	2,019	2,080	46,426	22.32	21
22	Other Administrative	10,276	10,879	193,879	17.82	22
23	Office Manager					23
24	Clerical					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	2,015	2,226	35,962	16.16	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	168,508	177,113	$ 3,623,106 *	$ 20.46	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		$ 12,240	1-3	35
36	Medical Director		39,000	9-3	36
37	Medical Records Consultant		4,800	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,759	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,540	11-3	44
45	Social Service Consultant				45
46	Other(specify) Reimbursement		24,000	21-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 85,339		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yehuda Hollander	Administrator	0	$ 104,239
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,239

B. Administrative - Other

Description	Amount
Aaron Topper - Mngmnt Fees	$ 386,206
TOTAL (agree to Schedule V, line 17, col. 3)	$ 386,206
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mendel S. Schneider	Accounting	$ 5,000
Benesch Friedlander Coplan & Aron	Legal	16,500
Law Offices of John A Culver	Legal	12,424
Prospect Resources	Recruitment	600
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 34,524

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,772
Unemployment Compensation Insurance	15,632
FICA Taxes	273,947
Employee Health Insurance	268,784
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K ER Match	31,902
TOTAL (agree to Schedule V, line 22, col.8)	$ 649,037

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 760	
Advertising	15,745
Health Care Council of Illinois	17,847
Various	990
Less: Public Relations Expense	( )
Non-allowable advertising	(15,745)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,597

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,226
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,226

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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. **Health Care Council of ILL, $17,847**

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

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

(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. $ **45,140** 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. $ **192,854**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? 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?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

(19) 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.