		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: 0053603

Facility Name: Pearl Pavilion

Address: 900 South Kiwanis Dr (Number) Freeport (City) 61032 (Zip Code)

County: Stephenson

Telephone Number: (815)235-6196 **Fax #** (815)235-5365

HFS ID Number:

Date of Initial License for Current Owners: 06/01/2015

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 01/01/2020 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)
(Type or Print Name)
(Title)

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

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

Facility Name & ID Number Pearl Pavilion # 0053603 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	109	Skilled (SNF)	109	39,894	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	39,894	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	14,690	1,341	4,950	20,981	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,690	1,341	4,950	20,981	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.59%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 06/01/2015

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/2015 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 4,884

Medicare Intermediary Wisconsin Physicians Service

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 Pearl Pavilion # 0053603 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	173,039	10,605	8,554	192,198		192,198		192,198			1
2	Food Purchase		120,115		120,115		120,115		120,115			2
3	Housekeeping	100,095	10,551	9,277	119,923		119,923		119,923			3
4	Laundry	17,178	5,545		22,723		22,723		22,723			4
5	Heat and Other Utilities			113,286	113,286		113,286		113,286			5
6	Maintenance	65,665		32,970	98,635		98,635	114	98,749			6
7	Other (specify):*											7
8	TOTAL General Services	355,977	146,816	164,087	666,880		666,880	114	666,994			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,279,335	159,169	111,792	1,550,296		1,550,296	(40,617)	1,509,679			10
10a	Therapy											10a
11	Activities	68,951	1,781		70,732		70,732		70,732			11
12	Social Services	74,094			74,094		74,094		74,094			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Allocated Benifets							4,560	4,560			15
16	TOTAL Health Care and Programs	1,422,380	160,950	135,792	1,719,122		1,719,122	(36,057)	1,683,065			16
	C. General Administration											
17	Administrative	128,342		355,993	484,335		484,335	(305,437)	178,898			17
18	Directors Fees											18
19	Professional Services			33,209	33,209		33,209	9,795	43,004			19
20	Dues, Fees, Subscriptions & Promotions			31,190	31,190		31,190	(6,074)	25,116			20
21	Clerical & General Office Expenses	149,386	13,663	171,768	334,817		334,817	(9,710)	325,107			21
22	Employee Benefits & Payroll Taxes			256,082	256,082		256,082		256,082			22
23	Inservice Training & Education											23
24	Travel and Seminar			166	166		166		166			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			127,690	127,690		127,690		127,690			26
27	Other (specify):* Allocated Benifets							16,238	16,238			27
28	TOTAL General Administration	277,728	13,663	976,098	1,267,489		1,267,489	(295,188)	972,301			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,056,085	321,429	1,275,977	3,653,491		3,653,491	(331,131)	3,322,360			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 Pearl Pavilion #0053603 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			76,986	76,986		76,986	179,617	256,603			30
31	Amortization of Pre-Op. & Org.							14,362	14,362			31
32	Interest			1,018	1,018		1,018	329,440	330,458			32
33	Real Estate Taxes							121,849	121,849			33
34	Rent-Facility & Grounds			652,913	652,913		652,913	(645,392)	7,521			34
35	Rent-Equipment & Vehicles			1,569	1,569		1,569		1,569			35
36	Other (specify):*											36
37	**TOTAL Ownership**			732,486	732,486		732,486	(124)	732,362			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		77,546	635,198	712,744		712,744		712,744			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,687	163,687		163,687		163,687			42
43	Other (specify):* **Bad Debt**			100,943	100,943		100,943	(100,943)				43
44	**TOTAL Special Cost Centers**		77,546	899,828	977,374		977,374	(100,943)	876,431			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,056,085	398,975	2,908,291	5,363,351		5,363,351	(432,198)	4,931,153			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 Pearl Pavilion # 0053603 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	4,354	30		9
10	Interest and Other Investment Income	(2,935)	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	(119,356)	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	(100,943)	43		24
25	Fund Raising, Advertising and Promotional	(6,110)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,543)	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)**	$ (233,533)		$	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)	(198,665)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (198,665)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (432,198)		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

Pearl Pavilion

ID# 0053603

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 Pearl Pavilion # 0053603 **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	114	0	0	0	0	0	0	0	0	114	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	114	0	0	0	0	0	0	0	0	114	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	(40,617)	0	0	0	0	0	0	0	0	(40,617)	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	4,560	0	0	0	0	0	0	0	0	4,560	15
16	**TOTAL Health Care and Programs**	0	0	(36,057)	0	0	0	0	0	0	0	0	(36,057)	16
	C. General Administration													
17	Administrative	0	0	(305,437)	0	0	0	0	0	0	0	0	(305,437)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	9,795	0	0	0	0	0	0	0	0	9,795	19
20	Fees, Subscriptions & Promotions	(6,110)	0	36	0	0	0	0	0	0	0	0	(6,074)	20
21	Clerical & General Office Expenses	(127,899)	1,299	116,890	0	0	0	0	0	0	0	0	(9,710)	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	16,238	0	0	0	0	0	0	0	0	16,238	27
28	**TOTAL General Administration**	(134,009)	1,299	(162,478)	0	0	0	0	0	0	0	0	(295,188)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(134,009)	1,299	(198,421)	0	0	0	0	0	0	0	0	(331,131)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pearl Pavilion **#** 0053603 **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 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)	
	D. Ownership													
30	Depreciation	4,354	175,263	0	0	0	0	0	0	0	0	0	179,617	30
31	Amortization of Pre-Op. & Org.	0	14,362	0	0	0	0	0	0	0	0	0	14,362	31
32	Interest	(2,935)	332,375	0	0	0	0	0	0	0	0	0	329,440	32
33	Real Estate Taxes	0	121,849	0	0	0	0	0	0	0	0	0	121,849	33
34	Rent-Facility & Grounds	0	(652,913)	7,521	0	0	0	0	0	0	0	0	(645,392)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,419	(9,064)	7,521	0	0	0	0	0	0	0	0	(124)	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):*	(100,943)	0	0	0	0	0	0	0	0	0	0	(100,943)	43
44	**TOTAL Special Cost Centers**	(100,943)	0	0	0	0	0	0	0	0	0	0	(100,943)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(233,533)	(7,765)	(190,900)	0	0	0	0	0	0	0	0	(432,198)	45

Facility Name & ID Number Pearl Pavilion # 0053603 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
See Page 6 supplemental		See Page 6 supplemental		See Page 6 supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	Rental Income	$ 652,913	Pearl pavilion realty	100.00%	$	$ (652,913)	1
2	V	32	Interest Expense		Pearl pavilion realty		332,375	332,375	2
3	V	30	Depreciation Expense		Pearl pavilion realty		175,263	175,263	3
4	V	31	Amortization expense		Pearl pavilion realty		14,362	14,362	4
5	V	21	Office		Pearl pavilion realty		1,299	1,299	5
6	V	33	Real Estate Tax		Pearl pavilion realty		121,849	121,849	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 652,913			$ 645,148	$ * (7,765)	14

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

Facility Name & ID Number Pearl Pavilion # 0053603 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical Salaries	$	SABA HEALTHCARE		$ 99,561	$ 99,561	15
16	V	27	Payroll Taxes		SABA HEALTHCARE		6,803	6,803	16
17	V	27	Employee Benifets		SABA HEALTHCARE		9,435	9,435	17
18	V	10	Nursing salary		SABA HEALTHCARE		59,608	59,608	18
19	V	20	Dues & Subs		SABA HEALTHCARE		36	36	19
20	V	19	Professional Fees		SABA HEALTHCARE		9,795	9,795	20
21	V	34	Rent		SABA HEALTHCARE		7,521	7,521	21
22	V	6	Repairs & Maintenance		SABA HEALTHCARE		114	114	22
23	V	21	Telephone		SABA HEALTHCARE		797	797	23
24	V	17	Salary Blonder		SABA HEALTHCARE		25,278	25,278	24
25	V	17	Salary Singer		SABA HEALTHCARE		25,278	25,278	25
26	V	21	Admin & General Expenses		SABA HEALTHCARE		16,532	16,532	26
27	V	15	Nursing Benifets		SABA HEALTHCARE		4,560	4,560	27
28	V								28
29	V	17	Management Fees	355,993	SABA HEALTHCARE			(355,993)	29
30	V	10	Rn Consultant	100,225	SABA HEALTHCARE			(100,225)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 456,218			$ 265,318	$ * (190,900)	39

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

Facility Name & ID Number Pearl Pavilion # 0053603 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	Kevin Chankin	2.5	Arista Healthcare	Naperville	Saba Healthcare	Skokie	Mgmt	1
2	Aaron Singer	24.375	Forest City Nursing & Rehab	Rockford	Pearl Pavilion Realty	Freeport	Bldg rental	2
3	Jeffrey Webster	1.75	Rock River Healthcare	Rockford				3
4	Shimon Webster	8.5	Parc Joliet Nursing	Joliet				4
5	Yeruchom Levovitz	8.5	Briar Place Nursing	Indian Head Park				5
6	Moshe Blonder	24.375	Spring Creek SNF	Joliet				6
7	Wissati Irrevocable trust	30						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 Pearl Pavilion # 0053603 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 Singer	Owner	Administrative	24.38	224,722	6.66	16.67	Allocated wage	$ 25,278	17-7	1
2	Moishe Blonder	Owner	Administrative	24.38	224,722	6.66	16.67	Allocated wages	25,278	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 50,556		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 Pearl Pavilion # 0053603 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 [X] NO [ ]

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

Name of Related Organization: SABA HEALTHCARE
Street Address: 3515 w Howard
City / State / Zip Code: Skokie, Il 60076
Phone Number: ((847)383-9104
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	21	Clerical Salaries	Number of Beds	1,078	6	$ 984,647	$ 984,647	109	$ 99,561	1
2	27	Payroll Taxes	Number of Beds	1,078	6	67,280		109	6,803	2
3	27	Employee Benifets	Number of Beds	1,078	6	93,316		109	9,435	3
4	10	Nursing salary	Number of Beds	1,078	6	589,519	589,519	109	59,608	4
5	20	Dues & Subs	Number of Beds	1,078	6	356		109	36	5
6	19	Professional Fees	Number of Beds	1,078	6	96,869		109	9,795	6
7	34	Rent	Number of Beds	1,078	6	74,385		109	7,521	7
8	6	Repairs & Maintenance	Number of Beds	1,078	6	1,130		109	114	8
9	21	Telephone	Number of Beds	1,078	6	7,884		109	797	9
10	17	Salary Blonder	Number of Beds	1,078	6	250,000	250,000	109	25,278	10
11	17	Salary Singer	Number of Beds	1,078	6	250,000	250,000	109	25,278	11
12	21	Admin & General Expenses	Number of Beds	1,078	6	163,497		109	16,532	12
13	15	Nursing Benifets	Number of Beds	1,078	6	45,098		109	4,560	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					$ 2,623,981	$ 2,074,166		$ 265,318	25

Facility Name & ID Number Pearl Pavilion # 0053603 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	Fifth Third Bank		X	Mortgage			$	$ 6,257,020			$ 332,375	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Fifth Third Bank		X	Working Capital							1,018	6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,257,020			$ 333,393	9
	B. Non-Facility Related*											
10	Interest income										(2,935)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,935)	14
15	TOTALS (line 9+line14)						$	$ 6,257,020			$ 330,458	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 Pearl Pavilion # 0053603 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.**	$ 82,587	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.)		$ 121,849	2
3. Under or (over) accrual (line 2 minus line 1).		$ 39,262	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 82,587	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.		$ 121,849	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	115,898	8
	2016	117,549	9
	2017	118,913	10
	2018	118,899	11
	2019	121,849	12

Beginning accrual adjusted to account for purchase of building

	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 Pearl Pavilion COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0053603

CONTACT PERSON REGARDING THIS REPORT Mendel Schneider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

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.	18-13-34-477-001	Nursing Home	$ 121,849.26	$ 121,849.26
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 121,849.26	$ 121,849.26

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 Pearl Pavilion # 0053603 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,800 B. General Construction Type: Exterior Block & Brick Frame _____ Number of Stories 2

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

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

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

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

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

None

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

1. Total Amount Incurred: 71,810 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 14,362 4. Dates Incurred: 06/01/2018

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		2018	$ 139,663	1
2					2
3	TOTALS			$ 139,663	3

Facility Name & ID Number Pearl Pavilion # 0053603 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		2018	1972	$ 5,130,974	$	40	$ 128,274	$ 128,274	$ 348,822	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Furnish/Install New Carrier 4 ton AC in Hallway			2015	4,550		20	228	228	1,253	9
10	Water Heater			2016	3,965		20	198	198	809	10
11	Repair PT/OT Room, Glass restoration Lobby/Nurse Station			2016	171,315		20	8,566	8,566	38,547	11
12	Camera Installations/Surveilance NVR			2016	15,000		20	750	750	3,438	12
13	Wiring-32 Cameras, Patch Panel and Cables			2016	8,623		20	431	431	1,976	13
14	Design-PT/OT Renovations, Glass restoration/Lobby/Nurse Station			2016	305,063		20	15,253	15,253	71,181	14
15	ML Group-Addt'l Charges Floor Remodel			2017	20,128		20	1,006	1,006	3,605	15
16	Mold Reedation/Pipe Insulation			2019	19,500		20	975	975	1,463	16
17	New Water Heater			2020	4,754		20	238	238	238	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	Financial Statement Depreciation					252,249			(252,249)		34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Pearl Pavilion # 0053603 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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,683,872	$ 252,249		$ 155,919	$ (96,330)	$ 471,332	70

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

Facility Name & ID Number Pearl Pavilion # 0053603 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	$ 1,002,971	$	$ 100,297	$ 100,297	10	$ 314,369	71
72	Current Year Purchases	3,870		387	387	10	387	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,006,841	$	$ 100,684	$ 100,684		$ 314,756	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 6,830,376	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 252,249	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 256,603	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,354	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 786,088	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 Pearl Pavilion # 0053603 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	Allocated from Saba				7,521			5
6								6
7	TOTAL				$ 7,521 **			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: $ 1,569 Description: Medical Equipment Rental
(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 Pearl Pavilion # 0053603 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.

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	39-3	hrs	$		$ 253,025	$		$ 253,025	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			33,917			33,917	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			303,596			303,596	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				65,242		65,242	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Dialysis	39-3				44,660			44,660	12
13	Other (specify): Lab & Xray	39-2					12,304		12,304	13
14	TOTAL			$		$ 635,198	$ 77,546		$ 712,744	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 Pearl Pavilion # 0053603 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	$ 1,450,433	$ 1,584,446	1
2	Cash-Patient Deposits	32,616	32,616	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,361,644	2,361,644	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,375	72,375	6
7	Other Prepaid Expenses	30,770	30,770	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from related	75,082	55,164	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,022,920	$ 4,137,015	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		101,260	13
14	Buildings, at Historical Cost		5,248,102	14
15	Leasehold Improvements, at Historical Cost	552,897	552,897	15
16	Equipment, at Historical Cost	10,978	990,341	16
17	Accumulated Depreciation (book methods)	(344,392)	(2,158,123)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		71,810	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(33,511)	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)**	$ 219,483	$ 4,772,776	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,242,403	$ 8,909,791	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 149405	$ 149,405	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,616	32,616	28
29	Short-Term Notes Payable	874,748	874,748	29
30	Accrued Salaries Payable	116,601	116,601	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,758	6,758	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,949	82,587	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	92,427	92,427	35
	Other Current Liabilities(specify):			
36	Defered Provider Relief Funds	517,561	517,561	36
37	Due to related parties	26,824	177,359	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,859,889	$ 2,050,062	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,257,020	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)**	$	$ 6,257,020	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,859,889	$ 8,307,082	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,382,514	$ 602,709	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,242,403	$ 8,909,791	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,657,456	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,657,456	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	725,058	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	( )	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)**	$ 725,058	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)**	$ 2,382,514	24 *

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

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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	$ 5,869,577	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,869,577	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***	2,935	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,935	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Gov Stimulus Income	215,897	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 215,897	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,088,409	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	666,880	31
32	Health Care	1,719,122	32
33	General Administration	1,267,489	33
	B. Capital Expense		
34	Ownership	732,486	34
	C. Ancillary Expense		
35	Special Cost Centers	813,687	35
36	Provider Participation Fee	163,687	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,363,351	40
41	**Income before Income Taxes (line 30 minus line 40)****	725,058	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 725,058	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,641,284	44
45	Private Pay - Net Inpatient Revenue	250,165	45
46	Medicare - Net Inpatient Revenue	2,726,742	46
47	Other-(specify) Insurance	24,100	47
48	Other-(specify) Med B	227,286	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,869,577	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 Basi 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	3,142	3,246	$ 140,887	$ 43.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,798	9,038	260,821	28.86	3
4	Licensed Practical Nurses	11,119	11,676	336,997	28.86	4
5	CNAs & Orderlies	36,367	37,754	508,209	13.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,814	2,061	32,421	15.73	8
9	Activity Director					9
10	Activity Assistants	6,557	6,876	68,951	10.03	10
11	Social Service Workers	3,188	3,424	74,094	21.64	11
12	Dietician					12
13	Food Service Supervisor	2,036	2,096	40,171	19.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,266	12,812	132,868	10.37	15
16	Dishwashers					16
17	Maintenance Workers	3,385	3,640	65,665	18.04	17
18	Housekeepers	6,700	6,887	100,095	14.53	18
19	Laundry	1,602	1,608	17,178	10.68	19
20	Administrator	4,181	4,384	128,342	29.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,717	9,241	149,386	16.17	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)	109,872	114,743	$ 2,056,085 *	$ 17.92	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	Monthly	$ 8,554	1-3	35
36	Medical Director	Monthly	24,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	100,225	10-3	38
39	Pharmacist Consultant	Monthly	5,312	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 138,091		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	208	6,255	10-3	52
53	TOTAL (lines 50 - 52)	208	$ 6,255		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kendra Richmond	Administrative		$ 44,221
Jane Kempel	Administrative		83,361
Roland Arreguin	Administrative		760
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 128,342

B. Administrative - Other

Description	Amount
Saba Healthcare	$ 355,993
TOTAL (agree to Schedule V, line 17, col. 3)	$ 355,993
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider	Accounting	$ 12,600
Marcum	Accounting	9,000
Holly Turner	Legal	250
Gulko Schwed	Legal	2,563
Gutnicki	Legal	191
Langhenry, Gillen, Lundquist & Joh	Legal	2,500
Personnel Planners	Ui tax Consultant	1,475
Meyer Magence	Legal	3,375
Zimmet	PDPM Review	1,255
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 33,209

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,150
Unemployment Compensation Insurance	10,977
FICA Taxes	157,290
Employee Health Insurance	53,665
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 256,082

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,877
Health Care Worker Background Check	
(Indicate # of checks performed)	2,000
Patient Background Checks	2,127
Health Care Council Of Illinois	16,557
Misc License	565
Advertising	6,110
Less: Public Relations Expense	( )
Non-allowable advertising	(6,110)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,116

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	166
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 166

**See instructions.

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI 16557**

(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? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,231** 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. $ **163,687**
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? **no** 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? **100**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(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.