

		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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.

<p>I. IDPH Facility ID Number: <u>0036467</u></p> <p>Facility Name: <u>PAVILION OF WAUKEGAN II</u></p> <p>Address: <u>2217 WASHINGTON STREET</u> <u>WAUKEGAN</u> <u>60085</u> Number City Zip Code</p> <p>County: <u>LAKE</u></p> <p>Telephone Number: <u>(847) 244-4100</u> Fax # <u>(847) 244-2183</u></p> <p>IDPA ID Number: <u>36-3724999</u></p> <p>Date of Initial License for Current Owners: <u>09/01/90</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>AARON SHPAYHER</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>AARON SHPAYHER</u> (Date) _____		(Title) <u>ADMINISTRATOR</u>	Paid Preparer	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number PAVILION OF WAUKEGAN II

0036467 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,785	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			6,631	6,631	8
9	SNF/PED					9
10	ICF	22,219	3,684	424	26,327	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,219	3,684	7,055	32,958	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.84%

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

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/90 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 20 and days of care provided 6,631

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number

PAVILION OF WAUKEGAN II

0036467

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	232,601	20,308	5,378	258,287		258,287		258,287		1
2	Food Purchase		177,026		177,026	(9,253)	167,773	(484)	167,289		2
3	Housekeeping	221,464	29,067		250,531		250,531		250,531		3
4	Laundry		21,392	1,898	23,290		23,290		23,290		4
5	Heat and Other Utilities			113,595	113,595		113,595		113,595		5
6	Maintenance	70,388	42,823	62,627	175,838		175,838		175,838		6
7	Other (specify):*			14,585	14,585		14,585		14,585		7
8	TOTAL General Services	524,453	290,616	198,083	1,013,152	(9,253)	1,003,899	(484)	1,003,415		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,618,495	149,224	8,812	1,776,531		1,776,531		1,776,531		10
10a	Therapy	144,990			144,990		144,990		144,990		10a
11	Activities	81,425	17,044	2,952	101,421		101,421		101,421		11
12	Social Services	30,515			30,515		30,515		30,515		12
13	CNA Training										13
14	Program Transportation			2,716	2,716		2,716		2,716		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,875,425	166,268	32,480	2,074,173		2,074,173		2,074,173		16
	C. General Administration										
17	Administrative	102,217			102,217		102,217		102,217		17
18	Directors Fees										18
19	Professional Services			119,205	119,205		119,205		119,205		19
20	Dues, Fees, Subscriptions & Promotions			53,761	53,761		53,761	(45,211)	8,550		20
21	Clerical & General Office Expenses	322,209	84,001	76,979	483,189		483,189	(15,786)	467,403		21
22	Employee Benefits & Payroll Taxes			586,881	586,881	9,253	596,134	(83,350)	512,784		22
23	Inservice Training & Education			5,061	5,061		5,061		5,061		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			8,154	8,154		8,154		8,154		25
26	Insurance-Prop.Liab.Malpractice			145,387	145,387		145,387		145,387		26
27	Other (specify):*										27
28	TOTAL General Administration	424,426	84,001	995,428	1,503,855	9,253	1,513,108	(144,347)	1,368,761		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,824,304	540,885	1,225,991	4,591,180		4,591,180	(144,831)	4,446,349		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	5,378
	REPAIRS & MAINTENANCE		0
			0
			5,378
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
	CONTRACTED LAUNDRY SERV.		1,898
			1,898
5	HEAT & OTHER UTILITIES		
	GAS HEAT		34,782
	ELECTRICITY		38,731
	WATER		19,657
	CABLE TV - LOBBY		20,425
			0
			113,595
6	MAINTENANCE		
	GROUND MAINTENANCE		13,659
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		17,775
	ELEVATOR MAINTENANCE & REPAIR		6,856
	OUTSIDE LABOR		22,349
	EXTERMINATING SERVICE		163
	FIRE SERVICE		1,825
			0
			0
			0
			62,627
7	OTHER		
	SCAVENGER		13,752
	SECURITY SERVICE		833
			14,585
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	18,000
			18,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		3,341
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,128
	PHARMACY CONSULTANT	XVIII B 39-2	0
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
	ENTEROSTOMAL THERAPY		4,343
			0
			8,812
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			0
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,952
			0
			2,952
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	2,716
		2,716
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
		0
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,505
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	106,700
		0
		119,205
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	37,376
	EMPLOYEE WANT ADS XIX F	350
	CONTRIBUTIONS VI 20 XIX F	300
	DUES & SUBSCRIPTIONS XIX F	6,374
	LICENSES & PERMITS XIX F	1,506
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	7,035
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	500
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	320
		53,761
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,680
	EQUIPMENT REPAIR & MAINTENANCE	17,300
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	15,786
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	2,929
	TELEPHONE	38,284
	MESSENGER SERVICE	0
		0
		76,979

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	212,072
	UNEMPLOYMENT COMPENSATION XIX D	41,953
	WORKERS COMPENSATION INSURANCE XIX D	78,369
	HOSPITALIZATION INSURANCE XIX D	155,110
	EMPLOYEE BENEFITS - OTHER XIX D	8,856
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	83,350
	PENSION/PROFIT SHARING PLANS XIX D	7,171
	CHICAGO HEAD TAX XIX D	0
		586,881
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	5,061
		5,061
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,154
		8,154
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	145,387
		145,387
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,225,991

PAVILION OF WAUKEGAN II
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	177,026	PATIENT MEALS	98874
LESS SALES TAX	(484)	ADD EMPLOYEE MEALS	5475
	-----		-----
NET FOOD	176,542	TOTAL MEALS/YEAR	104349
TOTAL PATIENT CENSUS	32,958	NET FOOD	176542
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	104349

TOTAL PATIENT MEALS	98874	COST PER MEAL	1.69
		TIME EMPLOYEE MEALS	5475
ADD # EMPLOYEE MEALS/DAY	15		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	9253
	-----		=====
TOTAL EMPLOYEE MEALS	5475		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			58,188	58,188		58,188	105,605	163,793		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			57,484	57,484		57,484	170,116	227,600		32
33	Real Estate Taxes			66,503	66,503		66,503		66,503		33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(360,000)			34
35	Rent-Equipment & Vehicles			21,731	21,731		21,731		21,731		35
36	Other (specify):*										36
37	TOTAL Ownership			563,906	563,906		563,906	(84,279)	479,627		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		270,097	5,242	275,339		275,339		275,339		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			59,678	59,678		59,678		59,678		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		270,097	64,920	335,017		335,017		335,017		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,824,304	810,982	1,854,817	5,490,103		5,490,103	(229,110)	5,260,993		45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	18,592	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(484)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(15,786)	21		18
19	Entertainment		20		19
20	Contributions	(800)	20		20
21	Owner or Key-Man Insurance	(83,350)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(37,376)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,035)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (126,239)		\$	30

OHF 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	2	
		Amount	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)	(102,871)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (102,871)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (229,110)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

PAVILION OF WAUKEGAN II

ID# 0036467

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6
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 II# 0036467

Report Period Beginning:

01/01/2005

Ending:

12/31/2005**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(484)	0	0	0	0	0	0	0	0	0	0	(484)	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	(484)	0	(484)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(45,211)	0	0	0	0	0	0	0	0	0	0	(45,211)	20
21	Clerical & General Office Expenses	(15,786)	0	0	0	0	0	0	0	0	0	0	(15,786)	21
22	Employee Benefits & Payroll Taxes	(83,350)	0	0	0	0	0	0	0	0	0	0	(83,350)	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	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(144,347)	0	(144,347)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(144,831)	0	(144,831)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number

PAVILION OF WAUKEGAN II

0036467

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	18,592	87,013	0	0	0	0	0	0	0	0	0	105,605	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	170,116	0	0	0	0	0	0	0	0	0	170,116	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(360,000)	0	0	0	0	0	0	0	0	0	(360,000)	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	18,592	(102,871)	0	(84,279)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(126,239)	(102,871)	0	(229,110)	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED				GWH LIMITED	WAUKEGAN	REAL ESTATE

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 360,000	GWH LIMITED		\$	\$ (360,000)	1
2	V							2
3	V							3
4	V	30 DEPRECIATION				87,013	87,013	4
5	V	32 INTEREST				170,116	170,116	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 360,000			\$ 257,129	\$ * (102,871)	14

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

Facility Name & ID Number

PAVILION OF WAUKEGAN II

#

0036467

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AARON SHPAYHER		ADMIN	12.00				SALARY	\$ 102,217	17-3	1
2	LAUREN SHPAYHER		CLERICAL	12.50				SALARY	20,058	21-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 122,275		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 II**

0036467 Report Period Beginning: **01/01/2005** Ending: **2/31/2005**

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 II

0036467

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	Name of Lender	2		3	4	5	6		7	8	9	10
		Related**					Purpose of Loan	Monthly Payment Required				
		YES	NO				Original	Balance				
A. Directly Facility Related												
Long-Term												
1	MB FINANCIAL		X	MORTGAGE	\$21,000.00	3/27/90	\$ 2,800,000	\$ 2,248,302	10/01/05	6.7500	\$ 170,116	1
2												2
3												3
4	SHAREHOLDERS LOAN	X		WORKING CAPITAL				929,699			23,305	4
5												5
Working Capital												
6	MANUFACTURERS BANK		X	WORKING CAPITAL			500,000	250,000		5.2500	34,179	6
7												7
8												8
9	TOTAL Facility Related				\$21,000.00		\$ 3,300,000	\$ 3,428,001			\$ 227,600	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,300,000	\$ 3,428,001			\$ 227,600	15

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.		\$	57,000	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.)		\$	61,003	2
3. Under or (over) accrual (line 2 minus line 1).		\$	4,003	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	62,500	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.		\$	66,503	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	42,117	8
	2001	49,738	9
	2002	56,065	10
	2003	56,124	11
	2004	61,003	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PAVILION OF WAUKEGAN II COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0036467

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-20-300-044</u>	<u>NURSING HOME</u>	\$ <u>56,912.21</u>	\$ <u>56,912.21</u>
2. <u>08-20-311-001</u>	<u></u>	\$ <u>4,090.86</u>	\$ <u>4,090.86</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
	TOTALS	\$ <u>61,003.07</u>	\$ <u>61,003.07</u>

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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number PAVILION OF WAUKEGAN II

0036467

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>36,213</u>		\$ <u>50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	36,213		\$ 50,000	3

Facility Name & ID Number PAVILION OF WAUKEGAN II

0036467

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99	1990		\$ 2,013,267	\$ 63,913	35	\$ 57,522	\$ (6,391)	\$ 810,102	4
5	10	1997	1997	442,537	11,347	35	12,644	1,297	92,720	5
6		1997	1997	61,628	3,292	35	1,761	(1,531)	12,914	6
7										7
8										8
	Improvement Type**									
9	VARIOUS		1990	3,819	121	20	191	70	2,180	9
10	VARIOUS		1991	20,693	657	20	1,035	378	15,286	10
11	VARIOUS		1992	18,034	573	20	902	329	12,028	11
12	VARIOUS		1993	65,797	1,597	20	3,290	1,693	41,388	12
13	VARIOUS		1994	2,679	20	20	134	114	1,782	13
14	VARIOUS		1995	7,348	188	20	367	179	4,899	14
15	CEILING & FLOOR TILES		1996	28,483	730	20	1,424	694	11,574	15
16	ELEVATOR REPAIRS		1996	13,930	357	20	697	340	6,549	16
17	WALLPAPER		1996	14,503	372	20	725	353	6,989	17
18	WALK IN FREEZER		1996	20,962	538	20	1,048	510	10,480	18
19	CEILING TILE & LIGHT FIXTURES		1997	5,721	147	20	286	139	2,574	19
20	FIRE ALARM/SPRINKLER SYSTEM		1997	4,468	115	20	223	108	2,407	20
21	HEATER/PLUMBING/ELECTRICAL WORK		1997	11,017	283	20	551	268	4,959	21
22	BLINDS/TILE/HANDRAILS/CUBICLE CURTAINS/WALLPAPER		1997	29,182	650	20	1,459	809	13,131	22
23	BASEMENT REHAB/NURSE STATION		1997	27,546	706	20	1,377	671	12,393	23
24	ROOFTOP AC/DUCT WORK		1997	4,800	123	20	240	117	2,160	24
25	LANDSCAPING/AWNING		1997	10,818	277	20	541	264	4,869	25
26	TELEPHONE EQUIP/AMPLIFIER/NURSE CALL SYSTEM		1997	17,870	458	20	894	436	8,046	26
27	DRAPES/LIGHT FIXTURES/WALL COVERINGS/CURTAINS		1998	51,388	1,318	20	2,569	1,251	20,552	27
28	CEILING TILES/SPRINKLER/ARCHITECT SERV		1998	11,802	303	20	590	287	4,720	28
29	SHOWER/PLUMBING WORK		1998	19,437	498	20	972	474	7,776	29
30	AC/CONDENSER/FIREPROOFING		1998	11,171	286	20	559	273	4,472	30
31	TELEPHONE EQUIPMENT		1998	4,118		20	206	206	1,648	31
32	BATHROOM REMODEL/FIXTURES/PLUMBING REPAIRS		1999	76,943	1,974	20	3,847	1,873	26,929	32
33	NURSE CALL/EMERGENCY PHONE		1999	3,588	92	20	179	87	1,253	33
34	ROOFTOP A/C		1999	11,873	304	20	594	290	4,158	34
35	ELEVATOR REPAIR/WALK IN UNIT REPAIR		1999	12,538	321	20	627	306	4,389	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 II

0036467

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	ROOFTOP A/C/EXHAUST FANS	2000	\$ 73,987	\$ 2,690	27.5	\$ 2,690	\$	\$ 15,623	37
38	ANTI SCALD EQUIPMENT/SPRINKLER HEADS	2000	3,821	341	7	546	205	2,984	38
39	KNOBSETS/DOOR RESTRICTOR	2000	3,278	293	7	468	175	2,594	39
40	REMODEL BATHROOM-TILE,SHOWER,LAVATORY, ETC	2001	25,906	942	27.5	942		4,658	40
41	A/C UNITS, FREON	2001	20,734	754	27.5	754		3,317	41
42	PHONES FOR RESIDENTS' ROOMS	2001	41,582	1,512	27.5	1,512		6,316	42
43	ELEVATOR/ELECTRIC REPAIR	2001	8,134	296	27.5	296		1,353	43
44	LAUNDRY ROOM REMODEL/FLOORING RES ROOM	2001	2,272	82	27.5	82		363	44
45	ELEVATOR RENOVATION	2002	97,675	3,552	27.5	3,552		12,216	45
46	DOORS	2002	1,715	62	27.5	62		217	46
47	VIDEO CABLING	2002	9,407	342	27.5	342		1,197	47
48	BOILER & ELEVATOR PUMPS	2002	21,580	785	27.5	785		2,747	48
49	A/C UNIT	2002	5,853	213	27.5	213		745	49
50	FIREPROOFING	2002	2,920	106	27.5	106		371	50
51	CENTRAL PANEL	2002	3,100	113	27.5	113		395	51
52	SMOKE ROOM	2002	1,408	51	27.5	51		178	52
53	DIALYSIS ROOM	2003	34,290	1,247	27.5	1,247		3,066	53
54	ELEVATOR	2003	2,120	77	27.5	77		189	54
55	CARPET & BASE	2003	5,119	186	27.5	186		457	55
56	COOLING & HEATING UNIT	2003	2,401	87	27.5	87		214	56
57	SPRINKLER SYSTEM	2003	5,376	196	27.5	196		481	57
58	FAN SHUTDOWN, DOOR LOCK & MONITOR SYSTEM	2004	37,570	1,366	27.5	1,366		1,992	58
59	DOORS WITH FRAMES / FIRE SMOKE DAMPERS	2004	10,245	373	27.5	373		544	59
60	CONCRETE SLAB FOR SHED	2004	2,240	81	27.5	81		118	60
61	ROOF REPLACEMENT / DRAINS & SOFIT	2004	86,928	3,161	27.5	3,161		4,610	61
62	PAINTING & CARPETING	2004	1,609	59	27.5	59		86	62
63	DOORS & FRAMES	2005	12,879	215	27.5	215		215	63
64	HEATING & AC REPAIRS	2005	30,067	501	27.5	501		501	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,582,176	\$ 111,243		\$ 117,517	\$ 6,274	\$ 1,223,074	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 338,111	\$ 17,487	\$ 33,811	\$ 16,324	10 YRS	\$ 193,022	71
72	Current Year Purchases	40,054	8,011	4,005	(4,006)	10 YRS	4,005	72
73	Fully Depreciated Assets	64,885					64,885	73
74								74
75	TOTALS	\$ 443,050	\$ 25,498	\$ 37,816	\$ 12,318		\$ 261,912	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	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)	\$ 4,075,226	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 136,741	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 155,333	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,592	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,484,986	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

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: _____*

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: \$ 12,045 Description: SEE SCHEDULE ATTACHED

(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	ADMINISTRATOR	1999 ACURA	\$ 630.00	\$ 4,410	17
18	ADMINISTRATOR	2005 ACURA	545.00	5,276	18
19					19
20					20
21	TOTAL		\$ #####	\$ 9,686	21

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. _____/2006 \$ _____

13. _____/2007 \$ _____

14. _____/2008 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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	39-3	hrs			5,242			5,242	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 prescripts				198,289		198,289	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES,LAB.RENTAL Other (specify):	39-3					71,808		71,808	13
14	TOTAL			\$		\$ 5,242	\$ 270,097		\$ 275,339	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.

Facility Name & ID Number PAVILION OF WAUKEGAN II

0036467

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 851	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,233,166		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	161,410		6
7	Other Prepaid Expenses	11,397		7
8	Accounts Receivable (owners or related parties)	118,658		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,525,482	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,064,745		15
16	Equipment, at Historical Cost	443,050		16
17	Accumulated Depreciation (book methods)	(600,365)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec OFFICERS LIFE INS)	319,523		22
23	Other(specify): DEPOSITS	60,344		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,287,297	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,812,779	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 886,516	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	517,845		29
30	Accrued Salaries Payable	114,014		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,947		31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,500		32
33	Accrued Interest Payable	1,510		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,596,332	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	929,699		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 929,699	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,526,031	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 286,748	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,812,779	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (23,851)	1
2	Restatements (describe):		2
3	CSV OFFICER LIFE INS.	319,523	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 295,672	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(8,924)	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)	\$ (8,924)	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)	\$ 286,748	24 *

* This must agree with page 17, line 47.

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,381,467	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,381,467	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	99,712	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 99,712	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 5,481,179	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,013,152	31
32	Health Care	2,074,173	32
33	General Administration	1,503,855	33
	B. Capital Expense		
34	Ownership	563,906	34
	C. Ancillary Expense		
35	Special Cost Centers	275,339	35
36	Provider Participation Fee	59,678	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,490,103	40
41	Income before Income Taxes (line 30 minus line 40)**	(8,924)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (8,924)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number PAVILION OF WAUKEGAN II

0036467

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,028	1,464	\$ 46,731	\$ 31.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,182	28,302	665,816	23.53	3
4	Licensed Practical Nurses	11,071	12,652	275,790	21.80	4
5	CNAs & Orderlies	52,012	55,807	596,057	10.68	5
6	CNA Trainees					6
7	Licensed Therapist	4,140	4,596	144,990	31.55	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,012	7,796	81,425	10.44	10
11	Social Service Workers	1,824	2,080	30,515	14.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,884	21,579	232,601	10.78	15
16	Dishwashers					16
17	Maintenance Workers	4,045	4,341	70,388	16.21	17
18	Housekeepers	23,747	25,772	221,464	8.59	18
19	Laundry					19
20	Administrator	2,064	2,080	102,217	49.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,887	12,736	322,209	25.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,840	2,080	34,101	16.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,736	181,285	\$ 2,824,304 *	\$ 15.58	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 5,378	1-3	35
36	Medical Director	18,000	9-3	36
37	Medical Records Consultant	1,128	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	0	10-3	39
40	Physical Therapy Consultant	0	10a-3	40
41	Occupational Therapy Consultant	0	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	2,952	11-3	44
45	Social Service Consultant	0	12-3	45
46	Other(specify)			46
47	<u>ENTEROSTOMAL THERAPY</u>	4,343		47
48				48
49	TOTAL (lines 35 - 48)	\$ 31,801		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0	10-3	50
51	Licensed Practical Nurses	0	10-3	51
52	Certified Nurse Assistants/Aides	0	10-3	52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number PAVILION OF WAUKEGAN II

0036467

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUN OF LONG TERM CARE \$6344
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,650 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES NO NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,678
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 9,253 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? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees