

Facility Name & ID Number PAVILION OF WAUKEGAN II

0036467 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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			6,482	6,482	8
9	SNF/PED					9
10	ICF	21,628	2,891	356	24,875	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,628	2,891	6,838	31,357	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.82%

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 6,482

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number

PAVILION OF WAUKEGAN II

0036467

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	209,513	25,374	8,502	243,389		243,389	0	243,389		1
2	Food Purchase		172,662		172,662	0	172,662	(1,200)	171,462		2
3	Housekeeping	225,015	22,259	0	247,274		247,274	0	247,274		3
4	Laundry	0	20,686	905	21,591	0	21,591	0	21,591		4
5	Heat and Other Utilities			123,286	123,286		123,286	0	123,286		5
6	Maintenance	70,491	50,990	61,520	183,001		183,001	0	183,001		6
7	Other (specify):*			16,024	16,024		16,024	0	16,024		7
8	TOTAL General Services	505,019	291,971	210,237	1,007,227	0	1,007,227	(1,200)	1,006,027		8
	B. Health Care and Programs										
9	Medical Director	0		14,250	14,250		14,250	0	14,250		9
10	Nursing and Medical Records	1,674,699	185,794	106,894	1,967,387		1,967,387	0	1,967,387		10
10a	Therapy	149,492		0	149,492		149,492	0	149,492		10a
11	Activities	85,288	22,032	2,424	109,744		109,744	0	109,744		11
12	Social Services	31,836		0	31,836		31,836	0	31,836		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	1,941,315	207,826	123,568	2,272,709	0	2,272,709	0	2,272,709		16
	C. General Administration										
17	Administrative	102,155		0	102,155		102,155	0	102,155		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			61,289	61,289		61,289	0	61,289		19
20	Dues, Fees, Subscriptions & Promotions			65,728	65,728		65,728	(47,156)	18,572		20
21	Clerical & General Office Expenses	349,369	59,686	88,331	497,386		497,386	(25,533)	471,853		21
22	Employee Benefits & Payroll Taxes			633,523	633,523	0	633,523	(89,404)	544,119		22
23	Inservice Training & Education			8,015	8,015		8,015	0	8,015		23
24	Travel and Seminar			0	0		0	0	0		24
25	Other Admin. Staff Transportation			11,794	11,794		11,794	0	11,794		25
26	Insurance-Prop.Liab.Malpractice			131,802	131,802		131,802	0	131,802		26
27	Other (specify):*			0	0		0	0	0		27
28	TOTAL General Administration	451,524	59,686	1,000,482	1,511,692	0	1,511,692	(162,093)	1,349,599		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,897,858	559,483	1,334,287	4,791,628	0	4,791,628	(163,293)	4,628,335		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	8,502
	REPAIRS & MAINTENANCE	0
		0
		8,502
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
	CONTRACTED LAUNDRY SVC	905
		905
5	HEAT & OTHER UTILITIES	
	GAS HEAT	43,981
	ELECTRICITY	37,667
	WATER	20,220
	CABLE TV - LOBBY	21,418
		0
		123,286
6	MAINTENANCE	
	GROUNDS MAINTENANCE	12,653
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	16,114
	ELEVATOR MAINTENANCE & REPAIR	3,124
	OUTSIDE LABOR	26,498
	EXTERMINATING SERVICE	1,188
	FIRE SERVICE	1,943
		0
		0
		0
		0
		61,520
7	OTHER	
	SCAVENGER	15,736
	SECURITY SERVICE	288
		0
		0
		16,024
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	14,250
		14,250

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	4,107
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	55,312
	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
	DAILYSIS SERVICES	41,800
	ENTEROSTOMAL THERAPY	5,675
		106,894
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 CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT 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	2,424
		0
		2,424
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT 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	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,484
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	48,805
		0
		61,289
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	43,096
	EMPLOYEE WANT ADS XIX F	6,033
	CONTRIBUTIONS VI 20 XIX F	250
	DUES & SUBSCRIPTIONS XIX F	7,442
	LICENSES & PERMITS XIX F	2,577
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	3,650
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	160
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,520
	PATIENT BACKGROUND CHECKS XIX F	0
		65,728
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	25,533
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	46,020
	MESSENGER SERVICE	0
	COMPUTER EXPENSE	16,778
		88,331

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	218,403
	UNEMPLOYMENT COMPENSATION XIX D	59,403
	WORKERS COMPENSATION INSURANC XIX D	90,484
	HOSPITALIZATION INSURANCE XIX D	164,339
	EMPLOYEE BENEFITS - OTHER XIX D	11,490
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	89,404
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		633,523
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	8,015
		8,015
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	11,794
		11,794
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	131,802
		131,802
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,334,287

PAVILION OF WAUKEGAN II
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	172,662	PATIENT MEALS	94071
LESS SALES TAX	(1,200)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	171,462	TOTAL MEALS/YEAR	94071
TOTAL PATIENT CENSUS	31,357	NET FOOD	171462
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	94071

TOTAL PATIENT MEALS	94071	COST PER MEAL	1.82
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

PAVILION OF WAUKEGAN II

#0036467

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			53,413	53,413		53,413	68,988	122,401			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			69,932	69,932		69,932	116,117	186,049			32
33	Real Estate Taxes			64,183	64,183		64,183	0	64,183			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(360,000)	0			34
35	Rent-Equipment & Vehicles			54,032	54,032		54,032	0	54,032			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			601,560	601,560	0	601,560	(174,895)	426,665			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		241,221	26,692	267,913		267,913	0	267,913			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			59,678	59,678		59,678	0	59,678			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	241,221	86,370	327,591	0	327,591	0	327,591			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,897,858	800,704	2,022,217	5,720,779	0	5,720,779	(338,188)	5,382,591			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	(9,564)	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	(1,200)	2		13
14	Non-Care Related Interest	(15,496)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(160)	20		17
18	Fines and Penalties	(25,533)	21		18
19	Entertainment	0	20		19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance	(89,404)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(43,096)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,650)	20		28
29	Other-Attach Schedule	0			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (188,353)		\$ 0	30

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)	(149,835)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (149,835)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (338,188)		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

BHF USE ONLY					
48	49	50	51	52	

PAVILION OF WAUKEGAN II

ID# 0036467

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PAVILION OF WAUKEGAN II# 0036467

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**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	(1,200)	0	0	0	0	0	0	0	0	0	0	(1,200)	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	(1,200)	0	0	0	0	0	0	0	0	0	0	(1,200)	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	(47,156)	0	0	0	0	0	0	0	0	0	0	(47,156)	20
21	Clerical & General Office Expenses	(25,533)	0	0	0	0	0	0	0	0	0	0	(25,533)	21
22	Employee Benefits & Payroll Taxes	(89,404)	0	0	0	0	0	0	0	0	0	0	(89,404)	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	(162,093)	0	0	0	0	0	0	0	0	0	0	(162,093)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(163,293)	0	0	0	0	0	0	0	0	0	0	(163,293)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PAVILION OF WAUKEGAN II# 0036467

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(9,564)	78,552	0	0	0	0	0	0	0	0	0	68,988	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,496)	131,613	0	0	0	0	0	0	0	0	0	116,117	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	(25,060)	(149,835)	0	(174,895)	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)	(188,353)	(149,835)	0	(338,188)	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		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				78,552	78,552	4
5	V	32 INTEREST				131,613	131,613	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			\$ 210,165	\$ * (149,835)	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:

01/01/2006

Ending:

12/31/2006

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					SALARY	\$ 102,155	17-3	1
2	LAUREN SHPAYHER		CLERICAL					SALARY	18,355	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	\$ 120,510		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: **01/01/2006** Ending: **2/31/2006**

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

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					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	MANUFACTURER BANK		X	MORTGAGE			\$	\$			\$	131,613						
2																		
3																		
4																		
5																		
Working Capital																		
6	NMANUFACTURER BANK		X	WORKING CAPITAL				635,000				39,256						
7																		
8	SHAREHOLDER LOAN	X		WORKING CAPITAL				944,879				15,180						
9	TOTAL Facility Related						\$	0	\$	1,579,879		\$	186,049					
B. Non-Facility Related*																		
10												15,496						
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	0	\$	0		\$	15,496					
15	TOTALS (line 9+line14)						\$	0	\$	1,579,879		\$	201,545					

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 2005 report.		\$	62,500	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.)		\$	61,950	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(550)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	62,400	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. LATE PAYMENT FEE TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	2,333	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	64,183	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	49,738	8
	2002	56,065	9
	2003	56,124	10
	2004	61,003	11
	2005	61,950	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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 2005 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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 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 2005 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 2005.

(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>57,741.59</u>	\$ <u>57,741.59</u>
2. <u>08-20-311-001</u>	<u>NURSING HOME</u>	\$ <u>4,208.39</u>	\$ <u>4,208.39</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>61,949.98</u>	\$ <u>61,949.98</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number PAVILION OF WAUKEGAN II

0036467

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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).

N/A

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:

01/01/2006 Ending: 12/31/2006

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 BHF 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)	\$ 867,624	4
5	10	1997	1997	442,537	11,347	35	12,644	1,297	105,364	5
6		1997	1997	61,628	3,292	35	1,761	(1,531)	14,675	6
7										7
8										8
	Improvement Type**									
9	VARIOUS		1990	3,819	121	20	191	70	2,371	9
10	VARIOUS		1991	20,693	657	20	1,035	378	16,321	10
11	VARIOUS		1992	18,034	573	20	902	329	12,930	11
12	VARIOUS		1993	65,797	1,597	20	3,290	1,693	44,678	12
13	VARIOUS		1994	2,679	20	20	134	114	1,916	13
14	VARIOUS		1995	7,348	188	20	367	179	5,266	14
15	CEILING & FLOOR TILES		1996	28,483	730	20	1,424	694	12,998	15
16	ELEVATOR REPAIRS		1996	13,930	357	20	697	340	7,246	16
17	WALLPAPER		1996	14,503	372	20	725	353	7,714	17
18	WALK IN FREEZER		1996	20,962	538	20	1,048	510	11,528	18
19	CEILING TILE & LIGHT FIXTURES		1997	5,721	147	20	286	139	2,860	19
20	FIRE ALARM/SPRINKLER SYSTEM		1997	4,468	115	20	223	108	2,630	20
21	HEATER/PLUMBING/ELECTRICAL WORK		1997	11,017	283	20	551	268	5,510	21
22	BLINDS/TILE/HANDRAILS/CUBICLE CURTAINS/WALLPAPER		1997	29,182	650	20	1,459	809	14,590	22
23	BASEMENT REHAB/NURSE STATION		1997	27,546	706	20	1,377	671	13,770	23
24	ROOFTOP AC/DUCT WORK		1997	4,800	123	20	240	117	2,400	24
25	LANDSCAPING/AWNING		1997	10,818	277	20	541	264	5,410	25
26	TELEPHONE EQUIP/AMPLIFIER/NURSE CALL SYSTEM		1997	17,870	458	20	894	436	8,940	26
27	DRAPES/LIGHT FIXTURES/WALL COVERINGS/CURTAINS		1998	51,388	1,318	20	2,569	1,251	23,121	27
28	CEILING TILES/SPRINKLER/ARCHITECT SERV		1998	11,802	303	20	590	287	5,310	28
29	SHOWER/PLUMBING WORK		1998	19,437	498	20	972	474	8,748	29
30	AC/CONDENSER/FIREPROOFING		1998	11,171	286	20	559	273	5,031	30
31	TELEPHONE EQUIPMENT		1998	4,118	0	20	206	206	1,854	31
32	BATHROOM REMODEL/FIXTURES/PLUMBING REPAIRS		1999	76,943	1,974	20	3,847	1,873	30,776	32
33	NURSE CALL/EMERGENCY PHONE		1999	3,588	92	20	179	87	1,432	33
34	ROOFTOP A/C		1999	11,873	304	20	594	290	4,752	34
35	ELEVATOR REPAIR/WALK IN UNIT REPAIR		1999	12,538	321	20	627	306	5,016	35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number PAVILION OF WAUKEGAN II

0036467

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	\$	\$ 18,313	37
38	ANTI SCALD EQUIPMENT/SPRINKLER HEADS	2000	3,821	341	7	546	205	3,530	38
39	KNOBSETS/DOOR RESTRICTOR	2000	3,278	293	7	468	175	3,062	39
40	REMODEL BATHROOM-TILE,SHOWER,LAVATORY, ETC	2001	25,906	942	27.5	942		5,600	40
41	A/C UNITS, FREON	2001	20,734	754	27.5	754		4,071	41
42	PHONES FOR RESIDENTS' ROOMS	2001	41,582	1,512	27.5	1,512		7,828	42
43	ELEVATOR/ELECTRIC REPAIR	2001	8,134	296	27.5	296		1,649	43
44	LAUNDRY ROOM REMODEL/FLOORING RES ROOM	2001	2,272	82	27.5	82		445	44
45	ELEVATOR RENOVATION	2002	97,675	3,552	27.5	3,552		15,768	45
46	DOORS	2002	1,715	62	27.5	62		279	46
47	VIDEO CABLING	2002	9,407	342	27.5	342		1,539	47
48	BOILER & ELEVATOR PUMPS	2002	21,580	785	27.5	785		3,532	48
49	A/C UNIT	2002	5,853	213	27.5	213		958	49
50	FIREPROOFING	2002	2,920	106	27.5	106		477	50
51	CENTRAL PANEL	2002	3,100	113	27.5	113		508	51
52	SMOKE ROOM	2002	1,408	51	27.5	51		229	52
53	DIALYSIS ROOM	2003	34,290	1,247	27.5	1,247		4,313	53
54	ELEVATOR	2003	2,120	77	27.5	77		266	54
55	CARPET & BASE	2003	5,119	186	27.5	186		643	55
56	COOLING & HEATING UNIT	2003	2,401	87	27.5	87		301	56
57	SPRINKLER SYSTEM	2003	5,376	196	27.5	196		677	57
58	FAN SHUTDOWN, DOOR LOCK & MONITOR SYSTEM	2004	37,570	1,366	27.5	1,366		3,358	58
59	DOORS WITH FRAMES / FIRE SMOKE DAMPERS	2004	10,245	373	27.5	373		917	59
60	CONCRETE SLAB FOR SHED	2004	2,240	81	27.5	81		199	60
61	ROOF REPLACEMENT / DRAINS & SOFIT	2004	86,928	3,161	27.5	3,161		7,771	61
62	PAINTING & CARPETING	2004	1,609	59	27.5	59		145	62
63	DOORS & FRAMES	2005	12,879	468	27.5	468		683	63
64	HEATING & AC REPAIRS	2005	30,067	1,094	27.5	1,094		1,595	64
65	SPRINKLERS SYSTEM / AC	2006	28,738	494	27.5	494		494	65
66	BRICK WORK	2006	20,870	359	27.5	359		359	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,631,784	\$ 112,942		\$ 119,216	\$ 6,274	\$ 1,342,290	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	\$ 74,129	\$ 21,424	\$ 7,413	\$ (14,011)	10 YRS	\$ 13,679	71
72	Current Year Purchases	42,598	6,087	4,260	(1,827)	10 YRS	4,260	72
73	Fully Depreciated Assets	292,736			0		291,736	73
74					0			74
75	TOTALS	\$ 409,463	\$ 27,511	\$ 11,673	\$ (15,838)		\$ 309,675	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 4,091,247	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 140,453	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 130,889	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,564)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,651,965	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: \$ **47,492** 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	2005 ACURA	\$ 545.00	\$ 6,540	17
18					18
19					19
20					20
21	TOTAL		\$ 545.00	\$ 6,540	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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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	39-3	hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			978			978	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				206,335		206,335	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES, LAB, RENTALS Other (specify):						60,600		60,600	13
14	TOTAL			\$		\$ 978	\$ 266,935		\$ 267,913	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: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ 852	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,538,918		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,901		6
7	Other Prepaid Expenses	12,237		7
8	Accounts Receivable (owners or related parties)	8,658		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,657,566	\$ 0	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	1,114,353		15
16	Equipment, at Historical Cost	485,648		16
17	Accumulated Depreciation (book methods)	(653,778)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	319,523		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS/CONSTR	60,344		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,326,090	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,983,656	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,168,616	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	635,000		29
30	Accrued Salaries Payable	115,607		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,892		31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,400		32
33	Accrued Interest Payable			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)	\$ 1,996,515	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,196,224		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)	\$ 1,196,224	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,192,739	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ (209,083)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,983,656	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 286,748	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 286,748	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(495,831)	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)	\$ (495,831)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (209,083)	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	\$ 5,156,050	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,156,050	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	68,898	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 68,898	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 0	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)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,224,948	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,007,227	31
32	Health Care	2,272,709	32
33	General Administration	1,511,692	33
	B. Capital Expense		
34	Ownership	601,560	34
	C. Ancillary Expense		
35	Special Cost Centers	267,913	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)*	\$ 5,720,779	40
41	Income before Income Taxes (line 30 minus line 40)**	(495,831)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (495,831)	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: **01/01/2006**

Ending:

12/31/2006

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	1,648	1,944	\$ 70,709	\$ 36.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,660	16,139	456,018	28.26	3
4	Licensed Practical Nurses	16,860	18,300	425,281	23.24	4
5	CNAs & Orderlies	56,406	60,293	639,967	10.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,520	8,228	149,492	18.17	8
9	Activity Director					9
10	Activity Assistants			85,288		10
11	Social Service Workers	1,880	2,116	31,836	15.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,441	21,141	209,513	9.91	15
16	Dishwashers					16
17	Maintenance Workers	3,790	4,342	70,491	16.23	17
18	Housekeepers	24,220	26,122	225,015	8.61	18
19	Laundry					19
20	Administrator	2,064	2,080	102,155	49.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,730	15,678	349,369	22.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,000	2,080	33,600	16.15	31
32	Other Health Care(specify)	1,827	1,943	49,124	25.28	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,046	180,406	\$ 2,897,858 *	\$ 16.06	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	M	\$ 8,502	1-3	35
36	Medical Director	O	14,250	9-3	36
37	Medical Records Consultant	N	55,312	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,424	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 80,488		49

C. CONTRACT NURSES

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

Facility Name & ID Number PAVILION OF WAUKEGAN II

0036467

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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. ICLTC \$6,905
- (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. \$ 8,829 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 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. \$ 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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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