

Facility Name & ID Number PAVILION OF WAUKEGAN# 0049809 Report Period Beginning: 1/01/08 Ending: 12/31/08

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	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,894</u>	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	<u>109</u>	TOTALS	<u>109</u>	<u>39,894</u>	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	<u>21,636</u>	<u>2,631</u>	<u>6,802</u>	<u>31,069</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,636</u>	<u>2,631</u>	<u>6,802</u>	<u>31,069</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.88%

D. How many bed-hold days during this year were paid by the Department?

None (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)

N/AF. 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 12/1/07

J. Was the facility purchased or leased after January 1, 1978?

YES Date 12/1/07 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 51 and days of care provided 6,273Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/01/08 Ending: 12/31/08

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	227,941	11,966	7,950	247,857		247,857		247,857		1
2	Food Purchase		170,101		170,101		170,101	(71)	170,030		2
3	Housekeeping	123,226	25,491		148,717		148,717		148,717		3
4	Laundry	70,228	13,470		83,698		83,698		83,698		4
5	Heat and Other Utilities			145,289	145,289		145,289		145,289		5
6	Maintenance	78,861	10,309	47,680	136,850		136,850	205	137,055		6
7	Other (specify):*										7
8	TOTAL General Services	500,256	231,337	200,919	932,512		932,512	134	932,646		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000		10,000		9
10	Nursing and Medical Records	1,694,536	155,421	6,974	1,856,931		1,856,931		1,856,931		10
10a	Therapy	58,408	3,292	235,875	297,575		297,575		297,575		10a
11	Activities	86,226	4,666	10,330	101,222		101,222		101,222		11
12	Social Services	52,171			52,171		52,171		52,171		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,891,341	163,379	263,179	2,317,899		2,317,899		2,317,899		16
	C. General Administration										
17	Administrative	59,908		235,486	295,394		295,394	(130,397)	164,997		17
18	Directors Fees										18
19	Professional Services			114,315	114,315		114,315	2,017	116,332		19
20	Dues, Fees, Subscriptions & Promotions			15,252	15,252		15,252	(4,132)	11,120		20
21	Clerical & General Office Expenses	217,912	23,984	40,513	282,409		282,409	77,372	359,781		21
22	Employee Benefits & Payroll Taxes			419,324	419,324		419,324		419,324		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,179	2,179		2,179		2,179		24
25	Other Admin. Staff Transportation			11,865	11,865		11,865	7,871	19,736		25
26	Insurance-Prop.Liab.Malpractice			108,949	108,949		108,949		108,949		26
27	Other (specify):*							9,537	9,537		27
28	TOTAL General Administration	277,820	23,984	947,883	1,249,687		1,249,687	(37,732)	1,211,955		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,669,417	418,700	1,411,981	4,500,098		4,500,098	(37,598)	4,462,500		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **PAVILION OF WAUKEGAN**

#0049809

Report Period Beginning:

1/01/08

Ending:

12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			12,079	12,079	12,079	306	12,385				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,453	29,453	29,453		29,453				32
33	Real Estate Taxes			63,576	63,576	63,576		63,576				33
34	Rent-Facility & Grounds			459,185	459,185	459,185	1,068	460,253				34
35	Rent-Equipment & Vehicles			95,321	95,321	95,321		95,321				35
36	Other (specify):*			8,105	8,105	8,105		8,105				36
37	TOTAL Ownership			667,719	667,719	667,719	1,374	669,093				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			333,564	333,564	333,564		333,564				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,841	59,841	59,841		59,841				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			393,405	393,405	393,405		393,405				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,669,417	418,700	2,473,105	5,561,222	5,561,222	(36,224)	5,524,998				45

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

Facility Name & ID Number **PAVILION OF WAUKEGAN**

0049809

Report Period Beginning: **1/01/08**

Ending: **12/31/08**

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(71)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,304)	21		19
20	Contributions	(1,250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(790)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,488)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (7,903)		\$	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)	(28,321)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (28,321)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (36,224)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

PAVILION OF WAUKEGAN

ID# 0049809

Report Period Beginning: 1/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	MISCELLANEOUS INCOME	\$ (9)	21	1
2	IL COUNCIL LTC - COPE	(3,479)	20	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	(3,488)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PAVILION OF WAUKEGAN

0049809

Report Period Beginning:

1/01/08

Ending:

12/31/08

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	(71)	0	0	0	0	0	0	0	0	0	0	(71)	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	205	0	0	0	0	0	0	0	0	205	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(71)	0	205	0	134	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	(130,397)	0	0	0	0	0	0	0	0	(130,397)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	2,017	0	0	0	0	0	0	0	0	2,017	19
20	Fees, Subscriptions & Promotions	(4,269)	0	137	0	0	0	0	0	0	0	0	(4,132)	20
21	Clerical & General Office Expenses	(3,563)	0	80,935	0	0	0	0	0	0	0	0	77,372	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	7,871	0	0	0	0	0	0	0	0	7,871	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	9,537	0	0	0	0	0	0	0	0	9,537	27
28	TOTAL General Administration	(7,832)	0	(29,900)	0	(37,732)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,903)	0	(29,695)	0	(37,598)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PAVILION OF WAUKEGAN# 0049809

Report Period Beginning:

1/01/08

Ending:

12/31/08

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	306	0	0	0	0	0	0	0	0	306	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	1,068	0	0	0	0	0	0	0	0	1,068	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	0	0	1,374	0	0	0	0	0	0	0	0	1,374	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)	(7,903)	0	(28,321)	0	0	0	0	0	0	0	0	(36,224)	45

Facility Name & ID Number PAVILION OF WAUKEGAN

0049809

Report Period Beginning:

1/01/08

Ending:

12/31/08

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
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

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	\$ 459,185	PAVILION OF WAUKEGAN REALTY, LLC		\$ 459,185	\$
2	V						
3	V						
4	V	19 LEGAL FEES	30,906	LAW OFFICE OF ABRAHAM GUTNICKI		30,906	
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 490,091			\$ 490,091	\$ *

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

Facility Name & ID Number PAVILION OF WAUKEGAN# 0049809Report Period Beginning: 1/01/08Ending: 12/31/08

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 Home Office	\$ 235,486	AA Healthcare Management, LLC	100.00%	\$		\$ (235,486)	15
16	V	5 Utilities		AA Healthcare Management, LLC					16
17	V	6 Repairs & Maintenance		AA Healthcare Management, LLC		205	205		17
18	V	17 Owners Compensation		AA Healthcare Management, LLC		105,089	105,089		18
19	V	19 Professional Fees		AA Healthcare Management, LLC		2,017	2,017		19
20	V	20 Fees, Subscriptions		AA Healthcare Management, LLC		137	137		20
21	V	21 Clerical Salaries		AA Healthcare Management, LLC		80,240	80,240		21
22	V	21 Office Expenses		AA Healthcare Management, LLC		695	695		22
23	V	24 Travel & Seminars		AA Healthcare Management, LLC					23
24	V	25 Transportation		AA Healthcare Management, LLC		7,871	7,871		24
25	V	26 Insurance		AA Healthcare Management, LLC					25
26	V	27 Employee Benefits		AA Healthcare Management, LLC		9,537	9,537		26
27	V	30 Depreciation		AA Healthcare Management, LLC		306	306		27
28	V	34 Rent		AA Healthcare Management, LLC		1,068	1,068		28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 235,486			\$ 207,165	\$ *	(28,321)	39

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/01/08 Ending: 12/31/08

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 TOPPER	OWNER/ADMIN	ADMINISTRATIVE	75.00	SEE ATTACHED	40	76.90	MGT FEES	\$ 105,089	17-07	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 105,089		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number PAVILION OF WAUKEGAN

0049809

Report Period Beginning: 1/01/08

Ending: 12/31/08

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 AA Healthcare Management
 Street Address 8320 Skokie Blvd.
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 983-4860
 Fax Number (847) 673-3379

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	6	Repairs & Maintenance	Patient Days	56,739	2	375	31,069	205	2		
3	17	Owners Compensation	Patient Days	56,739	2	191,917	31,069	105,089	3		
4	19	Professional Fees	Patient Days	56,739	2	3,683	31,069	2,017	4		
5	20	Fees, Subscriptions	Patient Days	56,739	2	250	31,069	137	5		
6	21	Clerical Salaries	Patient Days	56,739	2	146,537	146,537	31,069	80,240	6	
7	21	Office Expenses	Patient Days	56,739	2	1,269	31,069	695	7		
8	24	Travel & Seminars	Patient Days	56,739	2		31,069	0	8		
9	25	Transportation	Patient Days	56,739	2	14,375	31,069	7,871	9		
10	26	Insurance	Patient Days	56,739	2	0	31,069	0	10		
11	27	Employee Benefits	Patient Days	56,739	2	17,417	31,069	9,537	11		
12	30	Depreciation	Patient Days	56,739	2	558	31,069	306	12		
13	34	Rent Expense	Patient Days	56,739	2	1,950	31,069	1,068	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				\$	378,331	\$	146,537	\$	207,165	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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	LAKE FOREST BANK		X	LINE OF CREDIT				990,807		29,453	6									
7										7										
8										8										
9	TOTAL Facility Related						\$ 990,807			\$ 29,453	9									
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related						\$			\$	14									
15	TOTALS (line 9+line14)						\$ 990,807			\$ 29,453	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 2007 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	63,829	2
3. Under or (over) accrual (line 2 minus line 1).		\$	63,829	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(253)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	63,576	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	56,124	8	
	2004	61,003	9	
	2005	61,950	10	
	2006		11	
	2007	63,829	12	
Line 6 - Misc diff				

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PAVILION OF WAUKEGAN COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0049809

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>59,493.21</u>	\$ <u>59,493.21</u>
2. <u>08-20-311-001</u>	<u>NURSING HOME</u>	\$ <u>4,336.06</u>	\$ <u>4,336.06</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>63,829.27</u>	\$ <u>63,829.27</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number PAVILION OF WAUKEGAN

0049809 Report Period Beginning:

1/01/08 Ending:

12/31/08

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>36,213</u>		\$	1
2					2
3	TOTALS	36,213		\$	3

Facility Name & ID Number PAVILION OF WAUKEGAN

0049809

Report Period Beginning:

1/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELECTRIC			2008	10,292	154	39	154		154	9
10	LANDSCAPING			2008	5,106	106	20	106		106	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

*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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 15,398	\$ 260		\$ 260	\$	\$ 260	70

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

Facility Name & ID Number PAVILION OF WAUKEGAN # 0049809 Report Period Beginning: 1/01/08 Ending: 12/31/08

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	\$ 61,226	\$ 11,819	\$ 11,819	\$		\$ 11,819	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocation from AA HC Mgt		306	306				74
75	TOTALS	\$ 61,226	\$ 12,125	\$ 12,125	\$		\$ 11,819	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)	\$	76,624	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	12,385	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	12,385	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	12,079	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: _____

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

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 95,321 Description: Medical equip \$94,237; Copier \$1,084

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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>
--	---	--

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	10a-3	hrs	\$		\$ 109,505	\$		\$ 109,505	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			5,540			5,540	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			120,830			120,830	4
5	Physician Care	39-3	visits				175		175	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				281,822		281,822	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab/Dialysis</u>	39-3					51,567		51,567	12
13	Other (specify): _____									13
14	TOTAL			\$		\$ 235,875	\$ 333,564		\$ 569,439	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# 0049809Report Period Beginning: 1/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(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	\$ 55,722	\$	1
2	Cash-Patient Deposits	2,628		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,658,856		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,830		6
7	Other Prepaid Expenses	10,457		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,806,493	\$	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	15,398		15
16	Equipment, at Historical Cost	61,226		16
17	Accumulated Depreciation (book methods)	(12,078)		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 (specify):			22
23	Other(specify):	319,897		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 384,443	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,190,936	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 991,663	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,778		28
29	Short-Term Notes Payable	990,807		29
30	Accrued Salaries Payable	147,410		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,984		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	56,265		36
37	<u>Due Others</u>	331,767		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,547,674	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,547,674	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (356,738)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,190,936	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 52,987	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 52,987	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(182,725)	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	(227,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (409,725)	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)	\$ (356,738)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number PAVILION OF WAUKEGAN

0049809

Report Period Beginning: 1/01/08

Ending: 12/31/08

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	\$ 4,722,730	1
2	Discounts and Allowances for all Levels	(58,633)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,664,097	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	392,795	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 392,795	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	(2,783)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	310,087	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,292	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 321,596	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	Misc. Income	9	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,378,497	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	932,512	31
32	Health Care	2,317,899	32
33	General Administration	1,249,687	33
B. Capital Expense			
34	Ownership	667,719	34
C. Ancillary Expense			
35	Special Cost Centers	333,564	35
36	Provider Participation Fee	59,841	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,561,222	40
41	Income before Income Taxes (line 30 minus line 40)**	(182,725)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (182,725)	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 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**

0049809

Report Period Beginning: **1/01/08**

Ending:

12/31/08

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	2,007	2,123	\$ 91,133	\$ 42.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,115	14,216	465,958	32.78	3
4	Licensed Practical Nurses	16,291	19,653	501,731	25.53	4
5	CNAs & Orderlies	44,804	59,802	635,714	10.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,039	4,864	58,408	12.01	8
9	Activity Director					9
10	Activity Assistants	7,947	8,460	86,226	10.19	10
11	Social Service Workers	1,733	1,981	52,171	26.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,279	21,023	227,941	10.84	15
16	Dishwashers					16
17	Maintenance Workers	4,182	4,653	78,861	16.95	17
18	Housekeepers	11,778	12,531	123,226	9.83	18
19	Laundry	8,477	9,284	70,228	7.56	19
20	Administrator					20
21	Assistant Administrator	1,872	2,000	59,908	29.95	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,526	12,815	217,912	17.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,050	173,405	\$ 2,669,417 *	\$ 15.39	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	159	\$ 7,950	1-03	35
36	Medical Director	Monthly	10,000	9-03	36
37	Medical Records Consultant	80	4,224	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	34	1,867	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	273	\$ 24,041		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	24	1,024	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	24	\$ 1,024		53

Facility Name & ID Number **PAVILION OF WAUKEGAN**

0049809

Report Period Beginning: **1/01/08**

Ending: **12/31/08**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
AARON TOPPER	ADMINISTRATOR	75	\$ 0	Workers' Compensation Insurance	\$ 69,497	IDPH License Fee	\$ 1,503	
PEARL COLES	ASST ADM		59,908	Unemployment Compensation Insurance	49,111	Advertising: Employee Recruitment		
				FICA Taxes	201,147	Health Care Worker Background Check		
				Employee Health Insurance	92,528	(Indicate # of checks performed)	2,235	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING & MARKETING	790	
				401K		DUES & SUBSCRIPTIONS	5,963	
				EMPLOYEE BENEFITS-OTHER	7,041	LICENSES	1,282	
				EMPLOYEE PHYSICAL EXAMS		ALLOCATION FROM AA HC MGT	137	
						Less: Public Relations Expense	(790)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 59,908	TOTAL (agree to Schedule V, line 22, col.8)	\$ 419,324	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,120	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	2,179
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 2,179
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
ABRAHAM GUTNICKI	LEGAL		\$ 30,906					
FUQUA, WINTER & STILES	LEGAL		300					
MEYER MAGENCE	LEGAL		750					
FR&R	ACCOUNTING		36,990					
MELVYN I. GOODMAN & CO	ACCOUNTING		1,013					
VARIOUS	DATA PROCESSING		22,743					
PERSONNEL PLANNERS	UNEMPLYMT. CONSULTING		1,220					
VARIOUS	BILLING SERVICES		18,393					
PERFECT STAFFING SOL.	RECRUITMENT FEE		2,000					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 114,315					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PAVILION OF WAUKEGAN

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 COUNCIL LTC \$8,742
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (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? 3-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,820 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. \$ 59,841
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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? _____
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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 \$5,000, 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.