

Facility Name & ID Number Pearl Pavilion

0053603 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 N/A

	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,031	2,005	5,096	24,132	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,031	2,005	5,096	24,132	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.66%

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

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

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

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

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 06/01/2015

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/01/2015 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 109 and days of care provided 3,889

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Pearl Pavilion # 0053603 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	167,603	14,431	8,836	190,870		190,870		190,870		1
2	Food Purchase		126,288		126,288		126,288	362	126,650		2
3	Housekeeping	80,576	10,280		90,856		90,856	1,614	92,470		3
4	Laundry	22,346	9,657		32,003		32,003		32,003		4
5	Heat and Other Utilities			107,118	107,118		107,118	(7,444)	99,674		5
6	Maintenance	66,548		55,269	121,817		121,817	1,514	123,331		6
7	Other (specify):*										7
8	TOTAL General Services	337,073	160,656	171,223	668,952		668,952	(3,954)	664,998		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,278,559	31,652	147,227	1,457,438		1,457,438	(79,540)	1,377,898		10
10a	Therapy	32,365			32,365		32,365		32,365		10a
11	Activities	62,440	439		62,879		62,879		62,879		11
12	Social Services	102,753		825	103,578		103,578		103,578		12
13	CNA Training										13
14	Program Transportation			256	256		256		256		14
15	Other (specify):*							1,081	1,081		15
16	TOTAL Health Care and Programs	1,476,117	32,091	172,308	1,680,516		1,680,516	(78,459)	1,602,057		16
	C. General Administration										
17	Administrative	120,066		332,000	452,066		452,066	(225,639)	226,427		17
18	Directors Fees										18
19	Professional Services			71,132	71,132		71,132	(3,364)	67,768		19
20	Dues, Fees, Subscriptions & Promotions			26,329	26,329		26,329	(10,561)	15,768		20
21	Clerical & General Office Expenses	36,666		147,350	184,016		184,016	(49,698)	134,318		21
22	Employee Benefits & Payroll Taxes			244,406	244,406		244,406		244,406		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,513	1,513		1,513	2,771	4,284		24
25	Other Admin. Staff Transportation			11,094	11,094		11,094	1,111	12,205		25
26	Insurance-Prop.Liab.Malpractice			79,234	79,234		79,234	304	79,538		26
27	Other (specify):*							23,670	23,670		27
28	TOTAL General Administration	156,732		913,058	1,069,790		1,069,790	(261,406)	808,384		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,969,922	192,747	1,256,589	3,419,258		3,419,258	(343,819)	3,075,439		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.

Pearl Pavilion
Travel Detail
12/31/2018

Account Number	Date	Employee	Function	Description	
8600.6	12/31/2018	Kelly Schultz	Admissions	Mileage within Illinois	9,999.96
8600.6	12/31/2018	Various- Facility Employees	A&G	Mileage within Illinois- Facility Errands	1,093.90
	12/31/2018	Allocated From Saba Healthcare			1,111.00
<hr/>					12,204.86

Facility Name & ID Number

Pearl Pavilion

#0053603

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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							257,685	257,685			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,413	38,413		38,413	84,785	123,198			32
33	Real Estate Taxes			115,728	115,728		115,728	2,258	117,986			33
34	Rent-Facility & Grounds			450,357	450,357		450,357	(139,904)	310,453			34
35	Rent-Equipment & Vehicles			2,945	2,945		2,945		2,945			35
36	Other (specify):*											36
37	TOTAL Ownership			607,443	607,443		607,443	204,824	812,267			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		175,968	691,737	867,705		867,705		867,705			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			178,795	178,795		178,795		178,795			42
43	Other (specify):*			9,489	9,489		9,489	(9,489)				43
44	TOTAL Special Cost Centers		175,968	880,021	1,055,989		1,055,989	(9,489)	1,046,500			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,969,922	368,715	2,744,053	5,082,690		5,082,690	(148,484)	4,934,206			45

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

Pearl Pavilion

ID# 0053603

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medicare Sequestration	\$ (32,993)	21	1
2	Vending Income	(351)	02	2
3	Marketing	(9,489)	43	3
4	Bank Charges	(7,810)	21	4
5	Miscellaneous Income	(457)	21	5
6	PAC Dues	(8,823)	20	6
7	Building Co- Professional Fees	(19,350)	19	7
8	Building Co- Closing Costs	(150,535)	36	8
9	Medical Record Income	(422)	10	9
10	Non-Allowable Legal	(4,255)	19	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	(234,485)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pearl Pavilion

0053603

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(456)	0	818	0	0	0	0	0	0	0	0	362	2
3	Housekeeping	0	0	1,614	0	0	0	0	0	0	0	0	1,614	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(8,469)	0	1,025	0	0	0	0	0	0	0	0	(7,444)	5
6	Maintenance	0	0	1,514	0	0	0	0	0	0	0	0	1,514	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,925)	0	4,971	0	0	0	0	0	0	0	0	(3,954)	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	(422)	0	0	0	(79,118)	0	0	0	0	0	0	(79,540)	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	1,081	0	0	0	0	0	0	1,081	15
16	TOTAL Health Care and Programs	(422)	0	0	0	(78,037)	0	0	0	0	0	0	(78,459)	16
	C. General Administration													
17	Administrative	0	0	(132,130)	0	(93,509)	0	0	0	0	0	0	(225,639)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(23,605)	19,350	630	56	205	0	0	0	0	0	0	(3,364)	19
20	Fees, Subscriptions & Promotions	(10,726)	0	161	4	0	0	0	0	0	0	0	(10,561)	20
21	Clerical & General Office Expenses	(122,441)	0	57,154	0	15,589	0	0	0	0	0	0	(49,698)	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	358	0	2,413	0	0	0	0	0	0	2,771	24
25	Other Admin. Staff Transportation	0	0	0	0	1,111	0	0	0	0	0	0	1,111	25
26	Insurance-Prop.Liab.Malpractice	0	0	304	0	0	0	0	0	0	0	0	304	26
27	Other (specify):*	0	0	13,786	0	9,884	0	0	0	0	0	0	23,670	27
28	TOTAL General Administration	(156,772)	19,350	(59,737)	60	(64,307)	0	0	0	0	0	0	(261,406)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(166,119)	19,350	(54,766)	60	(142,344)	0	0	0	0	0	0	(343,819)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pearl Pavilion

0053603

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	257,685	0	0	0	0	0	0	0	0	0	0	257,685	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,719)	85,485	0	1,019	0	0	0	0	0	0	0	84,785	32
33	Real Estate Taxes	0	0	0	2,258	0	0	0	0	0	0	0	2,258	33
34	Rent-Facility & Grounds	0	(148,654)	12,815	(4,065)	0	0	0	0	0	0	0	(139,904)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(150,535)	150,535	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	105,431	87,366	12,815	(788)	0	0	0	0	0	0	0	204,824	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):*	(9,489)	0	0	0	0	0	0	0	0	0	0	(9,489)	43
44	TOTAL Special Cost Centers	(9,489)	0	0	0	0	0	0	0	0	0	0	(9,489)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(70,177)	106,716	(41,951)	(728)	(142,344)	0	0	0	0	0	0	(148,484)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Supplemental Schedule		See Supplemental Schedule		See Supplemental Schedule		

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 Rental Income	\$ 148,654	Pearl Pavilion Realty	100.00%	\$	(148,654)	1
2	V	32 Interest Expense		Pearl Pavilion Realty	100.00%	85,485	85,485	2
3	V	19 Professional Fees		Pearl Pavilion Realty	100.00%	19,350	19,350	3
4	V	36 Closing Costs		Pearl Pavilion Realty	100.00%	150,535	150,535	4
5	V							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		\$ 148,654			\$ 255,370	\$ * 106,716	14

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

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	02 Food	\$	Premier Healthcare & Financial Services	100.00%	\$ 818	\$	818	15
16	V	03 Housekeeping		Premier Healthcare & Financial Services	100.00%	1,614		1,614	16
17	V	05 Utilities		Premier Healthcare & Financial Services	100.00%	1,025		1,025	17
18	V	06 Repairs & Maintenance		Premier Healthcare & Financial Services	100.00%	1,514		1,514	18
19	V	17 Administrative Expenses		Premier Healthcare & Financial Services	100.00%	33,870		33,870	19
20	V	19 Professional Fees		Premier Healthcare & Financial Services	100.00%	630		630	20
21	V	20 Dues & Subscriptions		Premier Healthcare & Financial Services	100.00%	161		161	21
22	V	21 Clerical & General Salaries		Premier Healthcare & Financial Services	100.00%	54,089		54,089	22
23	V	21 Clerical & General Other Costs		Premier Healthcare & Financial Services	100.00%	3,065		3,065	23
24	V	24 Seminar & Education		Premier Healthcare & Financial Services	100.00%	358		358	24
25	V	26 Insurance		Premier Healthcare & Financial Services	100.00%	304		304	25
26	V	27 Employee Benefits		Premier Healthcare & Financial Services	100.00%	13,786		13,786	26
27	V	34 Rent Expense		Premier Healthcare & Financial Services	100.00%	12,815		12,815	27
28	V	17 Consulting Fees	166,000	Premier Healthcare & Financial Services	100.00%			(166,000)	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		\$ 166,000			\$ 124,049	\$ *	(41,951)	39

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

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	19 Professional Fees	\$	Premier HC Real Estate LLC	100.00%	\$ 56	\$	56	15
16	V	20 Dues & Subscriptions		Premier HC Real Estate LLC	100.00%	4		4	16
17	V	32 Interest Expense		Premier HC Real Estate LLC	100.00%	1,019		1,019	17
18	V	33 Real Estate Taxes		Premier HC Real Estate LLC	100.00%	2,258		2,258	18
19	V	34 Rental Income	4,065	Premier HC Real Estate LLC	100.00%			(4,065)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								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		\$ 4,065			\$ 3,337	\$ *	(728)	39

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

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	10 Nursing Salary	\$ 83,361	SABA Healthcare	100.00%	\$ 4,243	\$ (79,118)
16	V	15 Nursing Employee Benefits		SABA Healthcare	100.00%	1,081	1,081
17	V	17 Admin Salary- Related		SABA Healthcare	100.00%	59,763	59,763
18	V	17 Admin Salary- Non Related		SABA Healthcare	100.00%	12,728	12,728
19	V	19 Professional Fees		SABA Healthcare	100.00%	205	205
20	V	21 Admin & General Expenses		SABA Healthcare	100.00%	813	813
21	V	21 Admin & General Salary		SABA Healthcare	100.00%	14,776	14,776
22	V	24 Seminar & Education		SABA Healthcare	100.00%	2,413	2,413
23	V	25 Auto & Travel		SABA Healthcare	100.00%	1,111	1,111
24	V	27 Employee Benefits- Admin		SABA Healthcare	100.00%	9,884	9,884
25	V	17 Consulting Fees	166,000	SABA Healthcare	100.00%		(166,000)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 249,361			\$ 107,017	\$ * (142,344)

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

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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							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		\$			\$	0	\$ *

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

Facility Name & ID Number

Pearl Pavilion

0053603

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	Shimon Webster	Member	Administrative	8.50%	See Attached	2.26	5.65%	Alloc Salary	\$ 11,290	17-7	1
2	Yeruchom Levovitz	Member	Administrative	8.50%	See Attached	2.26	5.65%	Alloc Salary	11,290	17-7	2
3	Kevin Chankin	Member	Clerical	2.50%	See Attached	2.26	5.65%	Alloc Salary	11,290	17-7	3
4	Aaron Singer	Member	Administrative	21.38%	See Attached	4.85	12.12%	Alloc Pymt	24,244	17-7	4
5	Moshe Blonder	Member	Administrative	21.38%	See Attached	4.85	12.12%	Alloc Pymt	24,244	17-7	5
6	Jake Singer	Relative	Administrative	0.00%	See Attached	4.85	12.12%	Alloc Salary	11,274	17-7	6
7											7
8											8
9											9
10											10
11											11
12	As necessary, the amounts reported above have been adjusted to reflect only HFS allowable costs										12
13								TOTAL	\$ 93,632		13

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

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

Facility Name & ID Number Pearl Pavilion

0053603

Report Period Beginning:

01/01/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Pearl Pavilion

0053603

Report Period Beginning:

01/01/2018

Ending: 2/31/2018

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 Premier HC & Financial Services
 Street Address 8131 Monticello
 City / State / Zip Code Skokie, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 751-2027

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	02	Food	Resident Days	427,478	10	\$ 14,500	\$ 24,132	\$ 819	1	
2	03	Housekeeping	Resident Days	427,478	10	28,586	24,132	1,614	2	
3	05	Utilities	Resident Days	427,478	10	18,155	24,132	1,025	3	
4	06	Repairs & Maintenance	Resident Days	427,478	10	26,817	24,132	1,514	4	
5	17	Administrative Expenses	Resident Days	427,478	10	600,000	600,000	24,132	33,871	5
6	19	Professional Fees	Resident Days	427,478	10	11,167	24,132	630	6	
7	20	Dues & Subscriptions	Resident Days	427,478	10	2,851	24,132	161	7	
8	21	Clerical & General Salaries	Resident Days	427,478	10	958,147	958,147	24,132	54,089	8
9	21	Clerical & General Other Costs	Resident Days	427,478	10	54,299	24,132	3,065	9	
10	24	Seminar & Education	Resident Days	427,478	10	6,339	24,132	358	10	
11	26	Insurance	Resident Days	427,478	10	5,376	24,132	303	11	
12	27	Employee Benefits	Resident Days	427,478	10	244,216	24,132	13,786	12	
13	34	Rent Expense	Resident Days	427,478	10	227,000	24,132	12,815	13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,197,453	\$ 1,558,147	\$ 124,050	25	

Facility Name & ID Number Pearl Pavilion

0053603

Report Period Beginning:

01/01/2018

Ending: 2/31/2018

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 Premier HC Real Estate
 Street Address 8131 Monticello
 City / State / Zip Code Skokie, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 751-2027

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	19	Professional Fees	Resident Days	427,478	10	\$ 1,000	\$ 24,132	\$ 56	1
2	20	Dues & Subscriptions	Resident Days	427,478	10	75	24,132	4	2
3	32	Interest Expense	Resident Days	427,478	10	18,053	24,132	1,019	3
4	33	Real Estate Taxes	Resident Days	427,478	10	40,000	24,132	2,258	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					\$ 59,128	\$	\$ 3,337	25

Facility Name & ID Number Pearl Pavilion

0053603

Report Period Beginning:

01/01/2018

Ending: 2/31/2018

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 SABA Healthcare
 Street Address 3515 Howard Street, Suite 1001
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 383-9104
 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	10	Nursing Salary	Resident Days	199,072	5	\$ 35,000	\$ 24,132	\$ 4,243	1
2	15	Nursing Employee Benefits	Resident Days	199,072	5	8,921	24,132	1,081	2
3	17	Admin Salary- Related	Resident Days	199,072	5	493,000	93,000	59,763	3
4	17	Admin Salary- Non Related	Resident Days	199,072	5	105,000	105,000	12,728	4
5	19	Professional Fees	Resident Days	199,072	5	1,689	24,132	205	5
6	21	Admin & General Expenses	Resident Days	199,072	5	6,710	24,132	813	6
7	21	Admin & General Salary	Resident Days	199,072	5	121,894	121,894	14,776	7
8	24	Seminar & Education	Resident Days	199,072	5	19,907	24,132	2,413	8
9	25	Auto & Travel	Resident Days	199,072	5	9,165	24,132	1,111	9
10	27	Employee Benefits- Admin	Resident Days	199,072	5	81,540	24,132	9,884	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					\$ 882,827	\$ 354,894	\$ 107,017	25

Facility Name & ID Number Pearl Pavilion

0053603 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____) _____
 Fax Number (_____) _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Pearl Pavilion

0053603

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	MB Financial		X	Mortgage			\$	\$ 6,481,309			\$	85,485						
2																		
3																		
4																		
5																		
Working Capital																		
6	MB Financial		X	Line of Credit				462,000				27,200						
7	MB Financial		X	Cap Ex								11,213						
8	Allocated From Premier RE		X									1,019						
9	TOTAL Facility Related						\$	\$ 6,943,309			\$	124,917						
B. Non-Facility Related*																		
10	Interest Income		X									(1,719)						
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$	(1,719)						
15	TOTALS (line 9+line14)						\$	\$ 6,943,309			\$	123,198						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

Facility Name & ID Number Pearl Pavilion

0053603

Report Period Beginning:

01/01/2018 Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,800 B. General Construction Type: Exterior Brick & Block Frame _____ 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).

None

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	Facility		2018	\$ 139,663	1
2	Allocated From Premier Realty			1,073	2
3	TOTALS			\$ 140,736	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	109		2018	1972	\$ 5,130,974	\$	40	\$ 128,274	\$ 128,274	\$ 128,274
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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 and Improvement Costs-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)	\$	5,130,974	\$		\$ 128,274	\$ 128,274	\$ 128,274	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,130,974	\$		\$ 128,274	\$ 128,274	\$ 128,274	1
2	Furnish/Install New Carrier 4 Ton AC in Hallway	2015	4,550		20	228	228	797	2
3	Water Heater	2016	3,965		20	198	198	413	3
4	Repair PT/OT Room, Glass Restoration Lobby/Nurse Station Ren	2016	171,315		20	8,566	8,566	21,415	4
5	Camera Installations/Surveillance NVR	2016	15,000		20	750	750	1,938	5
6	Wiring- 32 Cameras, Patch Panel and Cables	2016	8,623		20	431	431	1,114	6
7	Design- PT/OT Renovation, Glass Restoration/Lobby/Nurse Statio	2016	305,063		20	15,253	15,253	40,675	7
8	MI Group- Add'l Charges Floor Remodel	2017	20,128		20	1,006	1,006	1,593	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,659,618	\$		\$ 154,707	\$ 154,707	\$ 196,220	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 5,659,618	\$		\$ 154,707	\$ 154,707	\$ 196,220	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	TOTAL (lines 1 thru 33)	\$ 5,659,618	\$		\$ 154,707	\$ 154,707	\$ 196,220	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 5,659,618	\$		\$ 154,707	\$ 154,707	\$ 196,220	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	TOTAL (lines 1 thru 33)	\$ 5,659,618	\$		\$ 154,707	\$ 154,707	\$ 196,220	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 5,659,618	\$		\$ 154,707	\$ 154,707	\$ 196,220	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	TOTAL (lines 1 thru 33)	\$ 5,659,618	\$		\$ 154,707	\$ 154,707	\$ 196,220	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 5,659,618	\$		\$ 154,707	\$ 154,707	\$ 196,220	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	TOTAL (lines 1 thru 33)	\$ 5,659,618	\$		\$ 154,707	\$ 154,707	\$ 196,220	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 5,659,618	\$		\$ 154,707	\$ 154,707	\$ 196,220	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	TOTAL (lines 1 thru 33)	\$ 5,659,618	\$		\$ 154,707	\$ 154,707	\$ 196,220	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 5,659,618	\$		\$ 154,707	\$ 154,707	\$ 196,220	1
2	Related Party Building Allocations								2
3	Allocated From Premier Real Estate	2011	21,023		35	601	601	4,805	3
4	Allocated From Premier Real Estate	2012	2,677		35	76	76	535	4
5									5
6									6
7									7
8	Related Party Leasehold Improvement Allocations								8
9	Allocated From Premier Real Estate	2011	37,391		20	1,870	1,870	14,956	9
10	Allocated From Premier Real Estate	2012	1,084		20	54	54	379	10
11									11
12									12
13	Allocated From Premier HC & Financial Services	2012	477		20	24	24	167	13
14	Allocated From Premier HC & Financial Services	2016	1,118		20	56	56	168	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,723,388	\$		\$ 157,388	\$ 157,388	\$ 217,230	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 5,723,388	\$		\$ 157,388	\$ 157,388	\$ 217,230	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	TOTAL (lines 1 thru 33)	\$ 5,723,388	\$		\$ 157,388	\$ 157,388	\$ 217,230	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 23,608	\$	\$ 2,361	\$ 2,361		\$ 15,839	71
72	Current Year Purchases	979,363		97,936	97,936		97,936	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,002,971	\$	\$ 100,297	\$ 100,297		\$ 113,775	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,867,095	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 257,685	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 257,685	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 331,005	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.

Pearl Pavilion
12/31/20018
Moveable Equipment

Prior Year Equipment	Cost	Book Depreicaton	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Pearl Pavilion	7,108	-	711	711	4,384
Premier Healthcare & Financial	4,152	-	415	415	2,723
Premier Real Estate	12,348	-	1,235	1,235	8,732
Pearl Pavilion Realty			-	-	
Total	23,608	-	2,361	2,361	15,839

Current Year Equipment	Cost	Book Depreicaton	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Pearl Pavilion					
Premier Healthcare & Financial					
Premier Real Estate					
Pearl Pavilion Realty	979,363	-	97,936	97,936	97,936
Total	979,363	-	97,936	97,936	97,936

Fully Depreciated Equipment	Cost	Book Depreicaton	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Pearl Pavilion					
Premier Healthcare & Financial					
Premier Real Estate					
Pearl Pavilion Realty					
Total	-	-	-	-	-

Total Equipment	Cost	Book Depreicaton	Straight Line Depreciation	Adjustment	Accumulated Depreciation
Pearl Pavilion	7,108	-	711	711	4,384
Premier Healthcare & Financial	4,152	-	415	415	2,723
Premier Real Estate	12,348	-	1,235	1,235	8,732
Pearl Pavilion Realty	979,363	-	97,936	97,936	97,936
Total	1,002,971	-	100,297	100,297	113,775

Facility Name & ID Number Pearl Pavilion

0053603

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Freeport Property LLC

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:		109		\$ 301,703			3
4	Additions							4
5								5
6	Allocated from Premier HC & Financial				8,750			6
7	TOTAL		109		\$ 310,453			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. _____ /2019 \$ _____

13. _____ /2020 \$ _____

14. _____ /2021 \$ _____

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: \$ 2,945 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

FACILITY NAME	Pearl Pavilion
FACILITY NUMBER	0053603
REPORT BEGINNING	01/01/2018
REPORT ENDING	12/31/2018

SUPPLEMENTAL SCHEDULE DETAILING EQUIPMENT RENTAL

EQUIPMENT RENTAL

<u>DESCRIPTION</u>	<u>AMOUNT</u>
COPIER	2,945

<u>Total</u>	<u>2,945</u>
--------------	--------------

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 278,225	\$		\$ 278,225	1
2	Licensed Speech and Language Development Therapist		hrs			66,472			66,472	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			340,585			340,585	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				101,671		101,671	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>See Attached</u>					6,456	74,297		80,753	13
14	TOTAL			\$		\$ 691,737	\$ 175,968		\$ 867,705	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 Pearl Pavilion

0053603

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(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	\$ 55,538	\$ 67,729	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,786,620	1,786,620	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,846	53,846	6
7	Other Prepaid Expenses	3,980	3,980	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	26,933	86,390	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,926,917	\$ 1,998,565	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		139,663	13
14	Buildings, at Historical Cost		5,130,974	14
15	Leasehold Improvements, at Historical Cost	528,643	528,643	15
16	Equipment, at Historical Cost	7,108	986,471	16
17	Accumulated Depreciation (book methods)	(117,713)	(117,713)	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): <u>See Attached</u>	20,666	823	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 438,704	\$ 6,668,862	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,365,621	\$ 8,667,426	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 387,605	\$ 387,605	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	462,000	462,000	29
30	Accrued Salaries Payable	75,730	75,730	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,812	17,812	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,949	82,587	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	32,747	32,747	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,018,844	\$ 1,058,482	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,481,309	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached</u>		150,535	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,631,844	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,018,844	\$ 7,690,326	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,346,777	\$ 977,101	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,365,621	\$ 8,667,426	48

*(See instructions.)

FACILITY NAME Pearl Pavilion
FACILITY NUMBER 0053603
REPORT BEGINNING 01/01/2018
REPORT ENDING 12/31/2018

SUPPLEMENTAL SCHEDULE DETAILING OTHER ASSETS AND LIABILITIES

OTHER CURRENT ASSETS (PAGE 17, LINE 09)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE FROM PRIOR OWNER	2,108	2,108
EMPLOYEE LOAN	788	788
DUE FROM COST REPORT	24,037	24,037
REAL ESTATE TAX ESCROW		59,457
	<hr/> 26,933	<hr/> 86,390

OTHER NON-CURRENT ASSETS (PAGE 17, LINE 23)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE FROM AFFILIATE	19,842	-
SECURITY DEPOSITS	824	824
	<hr/> 20,666	<hr/> 824

OTHER CURRENT LIABILITIES (PAGE 17, LINE 36)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE TO PRIOR OWNER	8,943	8,943
ACCRUED BED TAX	23,804	23,804
	<hr/> 32,747	<hr/> 32,747

OTHER NON-CURRENT LIABILITIES (PAGE 17, LINE 43)

DESCRIPTION	AMOUNT	CONSOLIDATED AMOUNT
DUE TO AFFILIATES		150,535
	<hr/> -	<hr/> 150,535

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 862,528	1
2	Restatements (describe):		2
3	Prior Year Bad Debt Expense	(67,351)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 795,177	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	660,600	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	(109,000)	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)	\$ 551,600	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,346,777	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pearl Pavilion

0053603

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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		Amount	
I. Revenue			
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,507,258	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,507,258	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,517	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,025	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)	\$ 3,542	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,719	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,719	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	230,771	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 230,771	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,743,290	30

2		Amount	
II. Expenses			
A. Operating Expenses			
31	General Services	668,952	31
32	Health Care	1,680,516	32
33	General Administration	1,069,790	33
B. Capital Expense			
34	Ownership	607,443	34
C. Ancillary Expense			
35	Special Cost Centers	877,194	35
36	Provider Participation Fee	178,795	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,082,690	40
41	Income before Income Taxes (line 30 minus line 40)**	660,600	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 660,600	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,754,089	44
45	Private Pay - Net Inpatient Revenue	348,623	45
46	Medicare - Net Inpatient Revenue	1,915,233	46
47	Other-(specify) <u>Hospice</u>	74,815	47
48	Other-(specify) <u>Commercial Insurance</u>	414,498	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,507,258	49

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

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

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

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

FACILITY NAME	Pearl Pavilion
FACILITY NUMBER	0053603
REPORT BEGINNING	01/01/2018
REPORT ENDING	12/31/2018

SUPPLEMENTAL SCHEDULE DETAILING OTHER INCOME

OTHER INCOME (PAGE 19, LINE 28)

<u>DESCRIPTION</u>	<u>AMOUNT</u>
MEDICAID W/O CO-INSURANCE	229,541
VENDING INCOME (ADJ PG 5A)	351
MEDICAL RECORD INCOME (ADJ PG 5A)	422
MISCELLANEOUS INCOME (ADJ PG 5A)	457
<hr/> TOTAL	<hr/> 230,771

Facility Name & ID Number Pearl Pavilion

0053603

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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	1,788	1,912	\$ 70,710	\$ 36.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,410	15,363	434,648	28.29	3
4	Licensed Practical Nurses	7,754	8,181	226,528	27.69	4
5	CNAs & Orderlies	39,919	41,931	531,524	12.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,956	2,157	32,365	15.00	8
9	Activity Director	1,933	2,095	25,381	12.12	9
10	Activity Assistants	3,297	3,588	37,059	10.33	10
11	Social Service Workers	3,776	4,055	102,753	25.34	11
12	Dietician					12
13	Food Service Supervisor	2,128	2,275	41,322	18.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,491	12,336	126,281	10.24	15
16	Dishwashers					16
17	Maintenance Workers	3,677	3,960	66,548	16.81	17
18	Housekeepers	7,319	7,722	80,576	10.43	18
19	Laundry	2,094	2,219	22,346	10.07	19
20	Administrator	2,040	2,160	79,656	36.88	20
21	Assistant Administrator	2,080	2,247	40,409	17.98	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,437	3,616	36,666	10.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,254	1,357	15,149	11.16	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>					33
34	TOTAL (lines 1 - 33)	110,353	117,174	\$ 1,969,922 *	\$ 16.81	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	185	\$ 8,836	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant			10-03	37
38	Nurse Consultant	Monthly	83,361	10-03	38
39	Pharmacist Consultant	Monthly	5,126	10-03	39
40	Physical Therapy Consultant			10A-03	40
41	Occupational Therapy Consultant			10A-03	41
42	Respiratory Therapy Consultant			10A-03	42
43	Speech Therapy Consultant			10A-03	43
44	Activity Consultant			11-03	44
45	Social Service Consultant	13	825	12-03	45
46	Other(specify)				46
47	Dialysis Consultant	Monthly	58,740	10-03	47
48					48
49	TOTAL (lines 35 - 48)	198	\$ 180,888		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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		
Jessica Devries	Asst. Admin	0.00%	\$ 21,198	Workers' Compensation Insurance	\$ 34,209	IDPH License Fee	\$		
Kendra Farrar	Asst. Admin	0.00%	10,805	Unemployment Compensation Insurance	10,487	Advertising: Employee Recruitment	4,133		
Kelly Holland	Asst. Admin	0.00%	8,407	FICA Taxes	147,700	Health Care Worker Background Check	1,946		
Michael Rhoe	Administrator	0.00%	76,499	Employee Health Insurance	45,998	(Indicate # of checks performed <u>195</u>)			
Heath Schiesher	Administrator	0.00%	3,157	Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues	8,824		
				Other Employee Expense	2,961	Licenses & Fees	700		
				Holiday Expense	4,052	Allocated From Premier HC & Financial	161		
						Allocated From Premier RE	4		
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()		
(List each licensed administrator separately.)			\$ 120,066			Non-allowable advertising	()		
						Yellow page advertising	()		
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		\$ 15,768	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 245,407		
Consulting Fees- Premier HC & Financial Services			\$ 166,000						
Consulting Fees- Saba Healthcare			166,000						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 332,000						
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Attached	Legal		\$ 14,663				Out-of-State Travel	\$	
Marcum	Accounting		15,242						
Prospect Resources	Energy Consulting		1,300						
Assurance	Safety Consulting		2,500				In-State Travel		
Reliable Health Systems	Data Processing		12,540						
Creative Technology	IT Support		8,028						
Point Click Care	Data Processing		11,528						
Zirmed	Data Processing-Claims Mgmt		575				Seminar Expense	1,512	
Experian	Claims Mgmt		127				Allocated From Premier HC & Financial	358	
Ability Network	Data Processing-Claims Mgmt		1,767				Allocated From Saba HC	2,413	
Mowery & Schoenfeld	Accounting		2,026						
See Supplemental Schedule			837				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 71,132					TOTAL	\$ 4,283

* Attach copy of IMRF notifications

**See instructions.

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	
			\$	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes		Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)			\$					
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$	TOTAL (agree to Sch. V, line 20, col. 8)	\$	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Aatrix	Tax Consulting		\$ 87			\$	Out-of-State Travel	\$
Murphy Consulting	Regulatory Consulting		750					
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 837	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$
(For legal fee disclosure, see page 39 of instructions)							TOTAL	

* Attach copy of IMRF notifications

**See instructions.

Pearl Pavilion
 Detail of Legal Expense
 12/31/2018

GL Account	Vendor	Date	Description of Service	Amount	Adjustment	Allowable
8380.6	Field & Goldberg	4/12/2018	Loan Modification	1,578.00	(1,578.00)	-
8380.6	Field & Goldberg	7/25/2018	Loan Modification	167.00	(167.00)	-
8380.6	Neal Gerber Eisenb	5/10/2017	Prior Year Legal Services	49.05	(49.05)	-
8380.6	Meyer Magence	12/28/2017	Prior Year Legal Services	375.00	(375.00)	-
8380.6	Meyer Magence	1/2/2018	General Counseling	225.00	-	225.00
8380.6	Meyer Magence	9/20/2018	General Counseling	75.00	-	75.00
8380.6	Meyer Magence	10/3/2018	General Counseling	75.00	-	75.00
8380.6	Meyer Magence	12/12/2018	General Counseling	75.00	-	75.00
8380.6	SB2	2/21/2018	Monthly PA Review	550.00	-	550.00
8380.6	SB2	3/23/2018	Prior Year Legal Services	1,577.78	(1,577.78)	-
8380.6	SB2	12/18/2018	Monthly PA Review	2,000.00	-	2,000.00
8380.6	SB2	3/12/2018	Monthly PA Review	194.36	-	194.36
8380.6	SB2	3/21/2018	Monthly PA Review	506.25	-	506.25
8380.6	SB2	2/17/2018	Monthly PA Review	2,000.00	-	2,000.00
8380.6	SB2	4/12/2018	Monthly PA Review	187.50	-	187.50
8380.6	Polsinelli	7/31/2018	Managed Care Contracting	3,821.00	(508.19)	3,312.81
8380.6	Polsinelli	10/31/2018	Managed Care Contracting	1,207.00	-	1,207.00
				14,662.94	(4,255.02)	10,407.92

Facility Name & ID Number Pearl Pavilion

0053603

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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. ILCLTC/HCCI- \$17,647
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,194 Line 10-02
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 178,795
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? 100%
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
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: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees