FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0049809

Facility Name: Pavilion of Waukegan

Address: 2217 Washington St (Number) Waukegan (City) 60085 (Zip Code)

County: Lake

Telephone Number: 847-244-4100 **Fax #** 847-244-2183

HFS ID Number:

Date of Initial License for Current Owners: 12/01/07

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		x	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David Shamsi **Telephone Number:** 847-983-4860
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Aaron Topper
(Title) President

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 **Phone # (217) 782-1630**

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	112	Skilled (SNF)	112	40,880	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	112	TOTALS	112	40,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI Medicaid Primary	5 MMAI Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
		Patient Days by Level of Care and Primary Source of Payment								
8	SNF	6,092	13,872	4,367	226	746	2,315	2,433	30,051	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	6,092	13,872	4,367	226	746	2,315	2,433	30,051	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 73.51%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/1/17

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 12/1/17 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter certified beds.
number of certified beds 112

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

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

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

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	340,362	27,661	17,236	385,259		385,259		385,259			1
2	Food Purchase		233,284		233,284		233,284		233,284			2
3	Housekeeping	241,784	29,187		270,971		270,971		270,971			3
4	Laundry	62,129	42,421		104,550		104,550		104,550			4
5	Heat and Other Utilities			103,784	103,784		103,784		103,784			5
6	Maintenance	47,460	15,684	112,386	175,530		175,530		175,530			6
7	Other (specify):*											7
8	**TOTAL General Services**	691,735	348,237	233,406	1,273,378		1,273,378		1,273,378			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,029,348	196,367	194,197	3,419,912		3,419,912		3,419,912			10
10a	Therapy			437,704	437,704		437,704		437,704			10a
11	Activities	100,989	9,984	4,350	115,323		115,323		115,323			11
12	Social Services	60,992			60,992		60,992		60,992			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,191,329	206,351	672,252	4,069,931		4,069,931		4,069,931			16
	C. General Administration											
17	Administrative	104,751		455,358	560,109		560,109		560,109			17
18	Directors Fees											18
19	Professional Services			53,910	53,910		53,910	833	54,743			19
20	Dues, Fees, Subscriptions & Promotions			14,511	14,511		14,511	(1,136)	13,375			20
21	Clerical & General Office Expenses	227,393		467,936	695,329		695,329	(167,636)	527,693			21
22	Employee Benefits & Payroll Taxes			675,081	675,081		675,081		675,081			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			221,787	221,787		221,787		221,787			26
27	Other (specify):*											27
28	**TOTAL General Administration**	332,144		1,888,583	2,220,727		2,220,727	(167,939)	2,052,788			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,215,208	554,588	2,794,240	7,564,036		7,564,036	(167,939)	7,396,097			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: 1/1/2025 Ending: 12/31/2025

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			73,777	73,777		73,777	157,221	230,998			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,777	8,777		8,777	229,419	238,196			32
33	Real Estate Taxes							54,856	54,856			33
34	Rent-Facility & Grounds			630,954	630,954		630,954	630,954	1,261,908			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							24,095	24,095			36
37	**TOTAL Ownership**			713,508	713,508		713,508	1,096,545	1,810,053			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			99,143	99,143		99,143		99,143			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			518,403	518,403		518,403		518,403			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			617,546	617,546		617,546		617,546			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,215,208	554,588	4,125,294	8,895,090		8,895,090	928,606	9,823,696			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: 1/1/2025 Ending: 12/31/2025

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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				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	(22,979)	21		18
19	Entertainment				19
20	Contributions	(9,250)	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	(135,407)	21		24
25	Fund Raising, Advertising and Promotional				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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (167,636)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (167,636)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Pavilion of Waukegan

ID# 0049809

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (1,136)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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28				28
29				29
30				30
31				31
32				32
33				33
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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**	(1,136)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	833	0	0	0	0	0	0	0	0	0	833	19
20	Fees, Subscriptions & Promotions	(1,136)	0	0	0	0	0	0	0	0	0	0	(1,136)	20
21	Clerical & General Office Expenses	(167,636)	0	0	0	0	0	0	0	0	0	0	(167,636)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(168,772)	833	0	0	0	0	0	0	0	0	0	(167,939)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(168,772)	833	0	0	0	0	0	0	0	0	0	(167,939)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	157,221	0	0	0	0	0	0	0	0	0	157,221	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	229,419	0	0	0	0	0	0	0	0	0	229,419	32
33	Real Estate Taxes	0	54,856	0	0	0	0	0	0	0	0	0	54,856	33
34	Rent-Facility & Grounds	0	630,954	0	0	0	0	0	0	0	0	0	630,954	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	24,095	0	0	0	0	0	0	0	0	0	24,095	36
37	**TOTAL Ownership**	0	1,096,545	0	0	0	0	0	0	0	0	0	1,096,545	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)**	(168,772)	1,097,378	0	0	0	0	0	0	0	0	0	928,606	45

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ (630,954)	Pavilion of Waukegan Realty		$	$ 630,954	1
2	V	32	Interest				229,419	229,419	2
3	V	33	Real Estate Taxes				54,856	54,856	3
4	V	30	Depreciation				157,221	157,221	4
5	V								5
6	V	36	MIP Insurance				24,095	24,095	6
7	V	26	Insurance						7
8	V	19	Professional Fees				833	833	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ (630,954)			$ 466,424	$ * 1,097,378	14

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

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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	$ *	39

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

STATE OF ILLINOIS **Ownership Listing-1**

Pavilion of Waukegan

ID# 0049809

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Aaron		Topper	Chicago	IL	75.00000	75.00000	100.00000	1
2	Joseph		Brandman	Chicago	IL	25.00000	25.00000		2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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51									51
52									52
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69									69
70									70
71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

Pavilion of Waukegan

ID# **0049809**

Report Period Beginning: **1/1/2025**

Ending: **12/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
87									87
88									88
89									89
90									90
91									91
92									92
93									93
94									94
95									95
96									96
97									97
98									98
99									99
100									100
101									101
102									102
103									103
104									104
105									105
106									106
107									107
108									108
109									109
110									110
111									111
112									112
113									113
114									114
115									115
116									116
117									117
118									118
119									119
120									120
121									121
122									122
123									123
124									124
125									125
126									126
127									127
128									128
129									129
130									130
131									131
132									132
133									133
134									134
135									135
136									136
137									137
138									138
139									139
140									140
141									141
142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.**

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Aarop Topper	Manager	Mgmt	0.75	690,727	20	40.00		$ 413,519	17-3	1
2	Joseph Brandman	Manager	Mgmt	0.25	94,530				41,840	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 455,359		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: 1/1/2025 Ending: 2/31/2025

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

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	54,856	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.)	$	54,856	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2025 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.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	54,856	7

Assessed Value from Real Estate Tax Bill:	2024	678,924	8
Real Estate Tax Bill for Calendar Year:	2020	77,345	9
	2021	76,357	10
	2022	58,651	11
	2023	56,994	12
	2024	54,856	13

FOR BHF USE ONLY

14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pavilion of Waukegan COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0049809

CONTACT PERSON REGARDING THIS REPORT David Shamsi

TELEPHONE 847-983-4860 FAX #: 847-673-3379

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20-300-044	Facility	$ 53,201.82	$ 53,201.82
2.	08-20-311-001	Facility	$ 1,653.88	$ 1,653.88
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,855.70	$ 54,855.70

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 _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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 Numb Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,160 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. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO No If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	36,213	2013	$ 460,000	1
2					2
3	TOTALS	36,213		$ 460,000	3

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	109		2013		$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11	Door Kickplates			2009	1,913		10			1,913	11
12	Elevator Pumps			2009	1,462		10			1,462	12
13											13
14	Door Alarm System			2009	1,089		10			1,089	14
15	Ciculating Pump- Hot water heater			2009	1,041		10			1,041	15
16	Space pack unit motor			2010	1,757		10			1,757	16
17											17
18	New Locks			2010	1,417		10			1,417	18
19	Elevator ICU Control Board			2011	956		10			956	19
20	Exit Door Device			2011	814		10			814	20
21	Sprinkler Heads			2011	540		10			540	21
22	Basement Tile Flooring			2011	964		10			964	22
23	Patio Door			2011	2,168		10			2,168	23
24											24
25	Freight for Smoke Shelter			2012	289		10			289	25
26	Roller Guides for Elevator			2012	704		10			704	26
27	Elevator Starter Contacts			2012	760		10			760	27
28	A/C Ignition Module			2012	557		10			557	28
29	Elevator Fire Equipment			2012	667		10			667	29
30	Remodeling Supplies for Rehab Room			2012	951	24	40	24		328	30
31	Recover 40 Doors			2012	1,025		10			1,025	31
32	Temperature Valve			2012	599		10			599	32
33	Remodeling Rooms 103 & 105			2012	4,850	121	40	121		1,655	33
34	Light Fixtures			2012	1,282	32	40	32		437	34
35	Elevator Door Restrictor			2012	523		10			523	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fire Exit Device for Doors	2012	$ 671	$	10	$	$	$ 671	37
38	3 Fire Sprinklers	2012	1,659		10			1,659	38
39	Energy Eff Lighting Fixtures	2012	28,345	709	40	709		9,570	39
40	1st Floor Flooring	2012	12,995	325	40	325		4,387	40
41	Elevator Control Relays	2012	635		10			635	41
42	Flat Bar in Nurses Station	2012	975		10			975	42
43	Wall Base & Flooring	2012	5,035	126	40	126		1,691	43
44	Heating & Cooling Pump	2012	514		10			514	44
45	Generator	2012	1,047		10			1,047	45
46	Flooring	2012	368	9	40	9		119	46
47	Pavement Sealer	2012	1,800		20			1,800	47
48	Flooring First Floor	2012	1,432		10			1,432	48
49	Elevator Guide Rollers	2012	545	20	27.5	20		255	49
50	Remodel Therapy Room, Dining Room, Lobby	2013	162,826	5,921	27.5	5,921		79,691	50
51	and Family Lounge								51
52	Lobby: Furnish and Installation of Sculpted								52
53	Wallpaper with Custom Logo								53
54	Corridor: Installation of New Floor and								54
55	Removal of Old Floor Throughout Entire Corridor								55
56	Therapy Room: Wallcovering and Flooring of								56
57	Entire Therapy Room								57
58	Dining Room: Wallcovering and New Flooring								58
59	Entire Dining Room								59
60	Family Lounge: Installation of New Walls and								60
61	Doors, Modifying Electric Power, Installation								61
62	of New Floor and New Carpet								62
63	OEM Pump Assembly	2014	1,346	49	27.5	49		582	63
64	Drywall for TVs	2014	916	33	27.5	33		379	64
65	Sprinklehead	2014	1,120	41	27.5	41		469	65
66	Wallpaper Residents Rooms								66
67	Sprinklers	2015	1,700	62	27.5	62		679	67
68	Rebuild Weil	2015	5,298	193	27.5	193		2,082	68
69									69
70	TOTAL (lines 4 thru 69)		$ 255,555	$ 7,665		$ 7,665	$	$ 130,302	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: 1/1/2025 Ending: 12/31/2025

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		$ 255,555	$ 7,665		$ 7,665	$	$ 130,302	1
2									2
3	New Sign	2015	1,656	110	15	110		1,372	3
4	Generator Valve	2015	2,195	80	27.5	80		817	4
5	Replace Elevator	2015	5,464	199	27.5	199		1,997	5
6	Remodel Resident Bathrooms and Analysis Room	2015	34,830	1,267	27.5	1,267		23,272	6
7	Removed and Replaced all Drywall in Mensroom & Kitchen Area								7
8	Demolition of Existing Drywall & Ceilings, Demolition of Existing Entry Closets								8
9	Build New Steel Stud Framing Around New Bathroom and								9
10	Enlarged All Area, Opened Up Bathroom Concrete Floors and								10
11	Relocated all Underground and Above Ground Waste and Water Lines								11
12	Purchased and Installed 3/1/C Heat Pump Units								12
13	Replace Generator	2016	2,195		15			1,463	13
14	New Lighted Sign	2016	13,740	916	15	916		8,702	14
15	Bathroom Exhaust	2016	7,800	520	15	520		4,940	15
16	Reception Area Enlarged by Demolishing Adm Office	2016	31,375	2,092	15	2,092		25,180	16
17	Install New Work Area, Lighting, Fish Tank and Signage								17
18	in Reception Area								18
19	Installed Partition Glass with Sandblasted Horizontal Frosted Stripe								19
20	Remodel 2 Guest Bathrooms and Bathroom in 102 & 116	2017	13,750	917	15	917		7,793	20
21	Remodel Sprinkler Room	2017	3,580	239	15	239		2,030	21
22	Repair Roof Flashing & Vents	2017	2,190	146	15	146		1,241	22
23	Replace Generator	2017	27,150	1,810	15	1,810		15,385	23
24	Replace 43 Handles & Locks	2017	7,841	523	15	523		4,444	24
25	Replace Boiler	2017	8,948	597	15	597		5,073	25
26	New Ejector Pump	2017	21,005	1,400	15	1,400		12,344	26
27	New Fire Panel	2017	7,800	520	15	520		4,420	27
28									28
29	New Conductor Unit	2017	7,300	487	15	487		4,138	29
30	New Sign	2017	13,740	916	15	916		9,158	30
31	New Heat Exchange First Floor	2017	2,540	169	15	169		1,438	31
32	Drain Medic	2017	1,112	74	15	74		629	32
33									33
34	TOTAL (lines 1 thru 33)		$ 471,766	$ 20,647		$ 20,647	$	$ 266,138	34

**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: 1/1/2025 Ending: 12/31/2025

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 12B, Carried Forward		$ 471,766	$ 20,647		$ 20,647	$	$ 266,138	1
2	Built New Office, Demolish Old Structure	2018	50,266	3,351	15	3,351		25,133	2
3	Pump Bearings	2019	3,360	224	15	224		1,456	3
4	Sewer	2019	1,456	97	15	97		631	4
5	Alarm	2019	5,123	342	15	342		2,222	5
6	Repair PVC Drain,Install ceramic Tile,Rodding Shower Drains	2019	2,420	161	15	161		1,048	6
7	Excavate Inside Laundry to Install Sump Pump	2019	4,610	307	15	307		1,997	7
8	Second Floor Remodeling	2020	54,977	2,749	20	2,749		10,995	8
9	Condensor Coil	2021	3,920	784	5	784		3,920	9
10	pump installation	2021	5,157	1,031	5	1,031		5,156	10
11	Repair of fresh air duct and new access door in laundry room	2021	8,827	1,765	5	1,765		8,826	11
12	Laundry room A/C Unit Replacement	2023	5,660	566	10	566		1,462	12
13	Water Pump Repair	2023	6,173	882	7	882		2,499	13
14	Pavement for parking lot	2023	17,400	1,740	10	1,740		4,205	14
15	Pavement for parking lot	2023	9,489	949	10	949		2,214	15
16	2 ejector pumps rebuild	2024	14,700	1,470	10	1,470		2,695	16
17	Deposit	2024	1,743	174	10	174		319	17
18	Part of larger parking lot project	2024	475	24	20	24		40	18
19	Sprinkler system repairs	2025	8,395	336	25	336		336	19
20	New hot water boiler for whole building	2025	7,425	371	25	371		371	20
21	Garbage disposal for kitchen	2025	1,970	328	5	328		328	21
22	Parking lot replacement	2025	44,380	2,056	8	2,056		2,056	22
23	Outdoor sign	2025	9,890	165	10	165		165	23
24	HVAC Pump	2025	5,800		10				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)		$ 745,382	$ 40,519		$ 40,519	$	$ 344,213	34

**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: 1/1/2025 Ending: 12/31/2025

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	$ 322,957	$ 21,317	$ 21,317	$	15	$ 160,114	71
72	Current Year Purchases	16,416	1,122	1,122		15	1,122	72
73	Fully Depreciated Assets	254,135					254,135	73
74								74
75	TOTALS	$ 593,508	$ 22,439	$ 22,439	$		$ 415,371	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	Facility	2013 Elkhart Coach	2013	$ 53,862	$	$	$		$ 53,862	76
77	Facility	2011 Toyota Camry	2011	19,418					19,418	77
78										78
79										79
80	TOTALS			$ 73,280	$	$	$		$ 73,280	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)	$ 1,872,170	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 62,958	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 62,958	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)	$ 832,864	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2026	$
13.	/2027	$
14.	/2028	$

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: $ 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 & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2025 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 272,812	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 277,287)	1,713,281	1,713,281	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	76,967	103,148	6
7	Other Prepaid Expenses	16,112	760,933	7
8	Accounts Receivable (owners or related parties)	211,467	211,467	8
9	Other(specify): EE loan	400	400	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,018,227	$ 3,062,041	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		460,000	13
14	Buildings, at Historical Cost		4,253,839	14
15	Leasehold Improvements, at Historical Cost	749,922	749,922	15
16	Equipment, at Historical Cost	647,370	669,084	16
17	Accumulated Depreciation (book methods)	(964,484)	(2,839,292)	17
18	Deferred Charges	111,972	111,972	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(45,576)	(45,576)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Security deposit, escrows	100,000	100,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 599,204	$ 3,459,949	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,617,431	$ 6,521,990	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 829,543	$ 829,543	26
27	Officer's Accounts Payable	96,271	(444,419)	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,063,967	2,063,967	29
30	Accrued Salaries Payable	167,080	167,080	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		55,000	32
33	Accrued Interest Payable		17,663	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	other accrued	31,148	31,879	36
37	other liabilities	240,190	240,190	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,428,199	$ 2,960,903	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,129,943	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)**	$	$ 8,129,943	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,428,199	$ 11,090,846	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (810,768)	$ (4,568,856)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,617,431	$ 6,521,990	48

*(See instructions.)

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,035,193	1
2	Restatements (describe):	(29,955)	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,005,238	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	103,832	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	(1,919,838)	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)**	$ (1,816,006)	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)**	$ (810,768)	24 *

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

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,725,294	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,725,294	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	209,823	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 209,823	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	29,321	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	24,187	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,616	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 57,124	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	**other**	6,681	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,681	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,998,922	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,273,378	31
32	Health Care	4,069,931	32
33	General Administration	2,220,727	33
	B. Capital Expense		
34	Ownership	713,508	34
	C. Ancillary Expense		
35	Special Cost Centers	99,143	35
36	Provider Participation Fee	518,403	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,895,090	40
41	**Income before Income Taxes (line 30 minus line 40)****	103,832	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 103,832	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 1,141,655.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	3,390,696.00	45
46	MMAI-Medicaid is the Primary Payer	1,067,414.00	46
47	MMAI-Medicare is the Primary Payer	55,241.00	47
48	Private Pay	183,132.00	48
49	Medicare Part A	1,594,782.00	49
50	Other-(specify) **VA**	470,567.00	50
51	Other-(specify) **Hospice**	495,067.00	51
52	Other-(specify) **Managed Care Medicare**	326,740.00	52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,725,294	56

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,259	2,259	$ 134,011	$ 59.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,640	21,640	937,483	43.32	3
4	Licensed Practical Nurses	13,762	13,762	499,507	36.30	4
5	CNAs & Orderlies	62,811	62,811	1,404,717	22.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,267	1,267	24,287	19.17	9
10	Activity Assistants	5,071	5,071	76,702	15.13	10
11	Social Service Workers	2,126	2,126	60,992	28.69	11
12	Dietician	12,536	12,536	220,349	17.58	12
13	Food Service Supervisor					13
14	Head Cook	7,344	7,344	120,013	16.34	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,289	1,289	36,372	28.22	17
18	Housekeepers	15,309	15,309	241,784	15.79	18
19	Laundry	4,113	4,113	62,129	15.11	19
20	Administrator	2,086	2,086	104,751	50.22	20
21	Assistant Administrator	7,994	7,994	182,801	22.87	21
22	Other Administrative					22
23	Office Manager	2,126	2,126	55,680	26.19	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,130	2,130	53,630	25.18	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,863	163,863	$ 4,215,208 *	$ 25.72	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 17,236		35
36	Medical Director		36,000		36
37	Medical Records Consultant		4,992		37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,929		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		24,459		42
43	Speech Therapy Consultant				43
44	Activity Consultant		4,350		44
45	Social Service Consultant				45
46	Other(specify) Reimb.		25,000		46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 118,966		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 857		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides		(54,083)		52
53	TOTAL (lines 50 - 52)		$ (53,226)		53

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anatoly Tabachnick	Administrator	0	$ 104,751
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,751

B. Administrative - Other

Description	Amount
Aaron Topper	$ 413,519
Joseph Brandman	41,839
TOTAL (agree to Schedule V, line 17, col. 3)	$ 455,358
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RothCo	Accounting	$ 8,500
Prospect Resources	Utility management	1,200
Stone Pogrund & Korey LLC	Legal	1,697
Future Care RRG	Legal	8,497
Gordon Rees Scully Mansukhani	Legal	14,488
Law Offices of John A Culver	Legal	1,060
Levin & Perconti	Legal	15,000
Otte & Czajkowska	Legal	3,468
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 53,910

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,128
Unemployment Compensation Insurance	39,639
FICA Taxes	315,106
Employee Health Insurance	217,139
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other EE Benefits	17,996
401K	31,073
TOTAL (agree to Schedule V, line 22, col.8)	$ 675,081

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,061
Health Care Worker Background Check	698
(Indicate # of checks performed 64)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	8,752
Less: Public Relations Expense	( )
PAC and Lobbying payments	(1,136)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,375

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number Pavilion of Waukegan # 0049809 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	7,616
	7,616 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	
Other, please specify IL Continuity of Care	105
Other, please specify Collaborative Healthcare Urgency Group	1,031
	1,136 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	7,616
Other, please specify IL Continuity of Care	105
	1,031
	8,752 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ _____ Line _____

(6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **518,403**
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) 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**

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(12) 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? _____ If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____

c. What percent of all travel expense relates to transportation of nurses and patients? _____

d. Have vehicle usage logs been maintained? _____

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____

g. Does the facility transport residents to and from day training? _____
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(13) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____

(14) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(15) 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.