FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 00039230

Facility Name: OTTAWA PAVILION LTD

Address: 800 E. CENTER STREET (Number) OTTAWA (City) 61350 (Zip Code)

County: LASALLE

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

HFS ID Number:

Date of Initial License for Current Owners: 12/01/1993

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
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 01/01/2011 to 12/31/2011 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) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	119	Skilled (SNF)	119	43,435	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	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	193	187	6,280	6,660	8
9	SNF/PED					9
10	ICF	22,359	6,033	745	29,137	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,552	6,220	7,025	35,797	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.42%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 12/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 119 and days of care provided 6,280

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	234,164	22,196	7,913	264,273		264,273		264,273			1
2	Food Purchase		203,735		203,735		203,735	(987)	202,748			2
3	Housekeeping	140,075	30,476		170,551		170,551		170,551			3
4	Laundry	73,604	18,543	2,516	94,663		94,663		94,663			4
5	Heat and Other Utilities			144,681	144,681		144,681	955	145,636			5
6	Maintenance	110,070	30,236	18,666	158,972		158,972	12,295	171,267			6
7	Other (specify):*			6,804	6,804		6,804	723	7,527			7
8	**TOTAL General Services**	557,913	305,186	180,580	1,043,679		1,043,679	12,986	1,056,665			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,949,935	76,770	39,287	2,065,992		2,065,992		2,065,992			10
10a	Therapy	516,392	328		516,720		516,720		516,720			10a
11	Activities	132,823	6,817	3,000	142,640		142,640		142,640			11
12	Social Services	32,037		2,000	34,037		34,037		34,037			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,631,187	83,915	50,287	2,765,389		2,765,389		2,765,389			16
	C. General Administration											
17	Administrative	80,766		148,806	229,572		229,572	(3,823)	225,749			17
18	Directors Fees											18
19	Professional Services			40,349	40,349		40,349	590	40,939			19
20	Dues, Fees, Subscriptions & Promotions			58,557	58,557		58,557	(43,507)	15,050			20
21	Clerical & General Office Expenses	68,588	23,090	385,021	476,699		476,699	(333,169)	143,530			21
22	Employee Benefits & Payroll Taxes			525,696	525,696		525,696		525,696			22
23	Inservice Training & Education			6,924	6,924		6,924		6,924			23
24	Travel and Seminar							691	691			24
25	Other Admin. Staff Transportation			18,337	18,337		18,337	(955)	17,382			25
26	Insurance-Prop.Liab.Malpractice			65,377	65,377		65,377	405	65,782			26
27	Other (specify):*			4,270	4,270		4,270	37,066	41,336			27
28	**TOTAL General Administration**	149,354	23,090	1,253,337	1,425,781		1,425,781	(342,702)	1,083,079			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,338,454	412,191	1,484,204	5,234,849		5,234,849	(329,716)	4,905,133			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#: OTTAWA PAVILION LTD **#00039230** **Report Period Beginning: 01/01/2011** **Ending: 12/31/2011**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,913	
	REPAIRS & MAINTENANCE		0	
			0	7,913
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,516	
			0	2,516
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		47,997	
	ELECTRICITY		73,010	
	WATER		16,694	
	CABLE TV - LOBBY		6,980	
			0	144,681
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		514	
	PAINTING & DECORATING		1,150	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		5,411	
	ELEVATOR MAINTENANCE & REPAIR		7,600	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,991	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	18,666
7	**OTHER**			
	SCAVENGER		6,804	
	SECURITY SERVICE		0	
			0	
			0	6,804
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	32,731	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	6,556	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	39,287
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,000	
			0	3,000
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,000	
				2,000
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number OTTAWA PAVILION LTD **#00039230** **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	148,806	148,806
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,993	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	26,356	
			0	40,349
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	43,353	
	EMPLOYEE WANT ADS	XIX F	3,016	
	CONTRIBUTIONS	VI 20 XIX F	300	
	DUES & SUBSCRIPTIONS	XIX F	5,192	
	LICENSES & PERMITS	XIX F	3,517	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,679	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				58,557
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,765	
	EQUIPMENT REPAIR & MAINTENANCE		16,403	
	OUTSIDE CLERICAL SERVICES		354,900	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		9,953	
	MESSENGER SERVICE		0	
			0	385,021

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	251,908	
	UNEMPLOYMENT COMPENSATION	XIX D	49,100	
	WORKERS COMPENSATION INSURANC	XIX D	132,567	
	HOSPITALIZATION INSURANCE	XIX D	79,213	
	EMPLOYEE BENEFITS - OTHER	XIX D	12,908	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	525,696
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		6,924	
				6,924
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		18,337	
				18,337
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		65,377	
				65,377
27	**OTHER**			
	BAD DEBTS	VI 24	4,270	
				4,270

GRAND TOTAL COLUMN 3 OTHER **1,484,204**

OTTAWA PAVILION LTD
SCHEDULES
12/31/2011

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	203,735
LESS SALES TAX	(987)
NET FOOD	202,748
TOTAL PATIENT CENSUS	35,797
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	107,391
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	107,391
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	107,391
NET FOOD	202,748
DIVIDE TOTAL MEALS/YEAR	107,391
COST PER MEAL	1.89
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number OTTAWA PAVILION LTD #00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			64,673	64,673		64,673	63,171	127,844			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,130	49,130		49,130	85,508	134,638			32
33	Real Estate Taxes							43,001	43,001			33
34	Rent-Facility & Grounds			276,000	276,000		276,000	(276,000)				34
35	Rent-Equipment & Vehicles			16,477	16,477		16,477	8,089	24,566			35
36	Other (specify):*											36
37	**TOTAL Ownership**			406,280	406,280		406,280	(76,231)	330,049			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		207,923	58,572	266,495		266,495		266,495			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		207,923	123,725	331,648		331,648		331,648			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,338,454	620,114	2,014,209	5,972,777		5,972,777	(405,947)	5,566,830			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 OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(17,371)	30		9
10	Interest and Other Investment Income	(1,959)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(987)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(800)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,270)	27		24
25	Fund Raising, Advertising and Promotional	(43,353)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(35,748)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (104,488)		$	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)	(301,459)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (301,459)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (405,947)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

OTTAWA PAVILION LTD

ID# 00039230

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ -33589	21	1
2	MARKETING TRAVEL	(2,159)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(35,748)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(987)	0	0	0	0	0	0	0	0	0	0	(987)	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	955	0	0	0	0	0	0	0	0	955	5
6	Maintenance	0	0	5,901	6,394	0	0	0	0	0	0	0	12,295	6
7	Other (specify):*	0	0	90	0	633	0	0	0	0	0	0	723	7
8	TOTAL General Services	(987)	0	6,946	6,394	633	0	0	0	0	0	0	12,986	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	(148,806)	0	144,983	0	0	0	0	0	0	0	(3,823)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	590	0	0	0	0	0	0	0	0	590	19
20	Fees, Subscriptions & Promotions	(44,153)	0	646	0	0	0	0	0	0	0	0	(43,507)	20
21	Clerical & General Office Expenses	(33,589)	(354,900)	47,721	7,599	0	0	0	0	0	0	0	(333,169)	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	691	0	0	0	0	0	0	0	0	691	24
25	Other Admin. Staff Transportation	(2,159)	0	1,204	0	0	0	0	0	0	0	0	(955)	25
26	Insurance-Prop.Liab.Malpractice	0	0	405	0	0	0	0	0	0	0	0	405	26
27	Other (specify):*	(4,270)	0	9,960	0	31,376	0	0	0	0	0	0	37,066	27
28	TOTAL General Administration	(84,171)	(503,706)	61,217	152,582	31,376	0	0	0	0	0	0	(342,702)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(85,158)	(503,706)	68,163	158,976	32,009	0	0	0	0	0	0	(329,716)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	(17,371)	78,620	1,922	0	0	0	0	0	0	0	0	63,171	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,959)	84,071	3,396	0	0	0	0	0	0	0	0	85,508	32
33	Real Estate Taxes	0	38,798	4,203	0	0	0	0	0	0	0	0	43,001	33
34	Rent-Facility & Grounds	0	(276,000)	0	0	0	0	0	0	0	0	0	(276,000)	34
35	Rent-Equipment & Vehicles	0	0	8,089	0	0	0	0	0	0	0	0	8,089	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(19,330)	(74,511)	17,610	0	0	0	0	0	0	0	0	(76,231)	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)**	(104,488)	(578,217)	85,773	158,976	32,009	0	0	0	0	0	0	(405,947)	45

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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	17	MANAGEMENT FEES	$ 148,806	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	$	$ (148,806)	1
2	V	21	BOOKKEEPING SERVICES	354,900	" "			(354,900)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	276,000	800 E. CENTER ST	100.00%		(276,000)	7
8	V	30	DEPRECIATION		" "		78,620	78,620	8
9	V	32	INTEREST		" "		84,071	84,071	9
10	V	33	REAL ESTATE TAXES		" "		38,798	38,798	10
11	V								11
12	V								12
13	V								13
14	Total			$ 779,706			$ 201,489	$ * (578,217)	14

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

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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	5	UTILITIES	$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	$ 955	$ 955	15
16	V	6	REPAIR & MAINT.		" " "		5,901	5,901	16
17	V	7	EMP. BEN. - GEN SERV		" " "		90	90	17
18	V	19	PROFESSIONAL FEES		" " "		590	590	18
19	V	20	DUES AND SUBSCRIPTION		" " "		646	646	19
20	V	21	CLERICAL & GENERAL		" " "		47,721	47,721	20
21	V	24	SEMINARS AND TRAVEL		" " "		691	691	21
22	V	25	AUTO EXPENSE		" " "		1,204	1,204	22
23	V	26	INSURANCE		" " "		405	405	23
24	V	27	EMP. BEN. - GEN, ADMIN.		" " "		9,960	9,960	24
25	V	30	DEPRECIATION		" " "		1,922	1,922	25
26	V	32	INTEREST		" " "		3,396	3,396	26
27	V	33	REAL ESTATE TAXES		" " "		3,574	3,574	27
28	V	33	RE TAX PROTEST FEES		" " "		629	629	28
29	V	35	EQUIPMENT RENTAL		" " "		8,089	8,089	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			$			$ 85,773	$ * 85,773	39

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

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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	6	MAINT COMP - D NEHMER	$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	$ 6,394	$ 6,394	15
16	V	17	ADMIN COMP - M MAUER		" " "		18,131	18,131	16
17	V	17	ADMIN COMP - M AARON		" " "		20,548	20,548	17
18	V	17	ADMIN COMP - F AARON		" " "				18
19	V	17	ADMIN COMP - S GOLDSTEIN		" " "		45,601	45,601	19
20	V	17	ADMIN COMP - S HARAMARAS		" " "				20
21	V	17	ADMIN COMP - D KUFTA		" " "		15,676	15,676	21
22	V	17	ADMIN COMP - HOWARD ALTER		" " "				22
23	V	17	ADMIN COMP - NON OWNER - V DAVIS		" " "		4,992	4,992	23
24	V	17	ADMIN COMP - NON OWNER - VAR		" " "		20,412	20,412	24
25	V	17	ADMIN COMP - NON OWNER - CFO		" " "		19,623	19,623	25
26	V	21	CLERICAL COMP - S AARON		" " "		7,599	7,599	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			$			$ 158,976	$ * 158,976	39

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

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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	7	EMP BEN - D NEHMER	$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	$ 633	$ 633	15
16	V	27	EMP BEN - M MAUER		" " "		996	996	16
17	V	27	EMP BEN - M AARON		" " "		1,153	1,153	17
18	V	27	EMP BEN - F AARON		" " "				18
19	V	27	EMP BEN - S GOLDSTEIN		" " "		16,632	16,632	19
20	V	27	EMP BEN - S HARAMARAS		" " "				20
21	V	27	EMP BEN - D KUFTA		" " "		1,102	1,102	21
22	V	27	EMP BEN - HOWARD ALTER		" " "				22
23	V	27	EMP BEN - V DAVIS		" " "		1,210	1,210	23
24	V	27	EMP BEN - NON OWNER		" " "		6,438	6,438	24
25	V	27	EMP BEN - NON OWNER - CFO		" " "		2,268	2,268	25
26	V	27	EMP BEN - S AARON		" " "		1,577	1,577	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			$			$ 32,009	$ * 32,009	39

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

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	MAURY AARON		ADMINISTRATIVE		SEE ATTACHED SCHEDULE			SALARY	$ 20,548	17-7	1
2	MARSHALL MAUER		ADMINISTRATIVE					SALARY	18,131	17-7	2
3	SHARON AARON		CLERICAL					SALARY	7,599	21-7	3
4	DENNIS NEHMER		MAINTENANCE					SALARY	6,394	6-7	4
5	DIANA KUFTA		ADMINISTRATIVE					SALARY	15,676	17-7	5
6	S GOLDSTEIN		ADMINISTRATIVE					SALARY	45,601	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 113,949		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 OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

Name of Related Organization: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN ST
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	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	5	UTILITIES	TOTAL PATIENT DAYS	416,329	14	$ 11,113	$	35,797	$ 955	1
2	6	REPAIRS & MAINTENANCE	TOTAL PATIENT DAYS	416,329	14	68,628	12,499	35,797	5,901	2
3	7	EMP BEN- GEN SERV	TOTAL PATIENT DAYS	416,329	14	1,044		35,797	90	3
4	19	PROFESSIONAL FEES	TOTAL PATIENT DAYS	416,329	14	6,858		35,797	590	4
5	20	DUES & SUBSCRIPTIONS	TOTAL PATIENT DAYS	416,329	14	7,513		35,797	646	5
6	21	CLERICAL & GENERAL	TOTAL PATIENT DAYS	416,329	14	555,005	401,070	35,797	47,721	6
7	24	SEMINARS & TRAVEL	TOTAL PATIENT DAYS	416,329	14	8,041		35,797	691	7
8	25	AUTO EXPENSE	TOTAL PATIENT DAYS	416,329	14	14,007		35,797	1,204	8
9	26	INSURANCE	TOTAL PATIENT DAYS	416,329	14	4,707		35,797	405	9
10	27	EMP BEN- GEN ADMIN	TOTAL PATIENT DAYS	416,329	14	115,833		35,797	9,960	10
11	30	DEPRECIATION	TOTAL PATIENT DAYS	416,329	14	22,348		35,797	1,922	11
12	32	INTEREST	TOTAL PATIENT DAYS	416,329	14	39,492		35,797	3,396	12
13	33	REAL ESTATE TAXES	TOTAL PATIENT DAYS	416,329	14	41,569		35,797	3,574	13
14	33	RE TAX PROTEST FEES	TOTAL PATIENT DAYS	416,329	14	7,315		35,797	629	14
15	35	EQUIPMENT RENTAL	TOTAL PATIENT DAYS	416,329	14	94,081		35,797	8,089	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 997,554	$ 413,569		$ 85,773	25

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

Name of Related Organization: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN ST
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	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	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	8	$ 62,231	$ 62,231	4	$ 6,394	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	10	200,000	200,000	4	18,131	2
3	17	AMNIN COMP - M AARON	WGHTD AVG HOURS	40	8	200,000	200,000	4	20,548	3
4	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	45	5	68,000	68,000			4
5	17	ADMIN COMP - J AARON	WGHTD AVG HOURS	40	2	121,602	121,602	15	45,601	5
6	17	ADMIN COMP - S KOPLIN	WGHTD AVG HOURS	40	4	74,106	74,106			6
7	17	ADMIN COMP - D MAGAFAS	WGHTD AVG HOURS	50	8	152,525	152,525	5	15,676	7
8	17	ADMIN COMP - H ALTER	WGHTD AVG HOURS	50	1	12,000	12,000			8
9	17	ADMIN COMP - NON OWNER	WGHTD AVG HOURS	40	8	74,874	74,874	3	4,992	9
10	17	ADMIN COMP - NON OWNER	WGHTD AVG HOURS	45	8	198,817	198,817	5	20,412	10
11	17	ADMIN COMP - NON OWNER	WGHTD AVG HOURS	45	10	216,469	216,469	4	19,623	11
12	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	10	83,751	83,751	4	7,599	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					$ 1,464,375	$ 1,464,375		$ 158,976	25

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

Name of Related Organization: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN ST
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	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	7	EMP BEN - D NEHMER	WGHTD AVG HOURS	40	8	$ 6,161	$	4	$ 633	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	10	10,982		4	996	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	8	11,224		4	1,153	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	43,917				4
5	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	44,352		15	16,632	5
6	27	EMP BEN - S KOPLIN	WGHTD AVG HOURS	40	4	30,190				6
7	27	EMP BEN - D MAGAFAS	WGHTD AVG HOURS	50	8	10,718		5	1,102	7
8	27	EMP BEN - H ALTER	WGHTD AVG HOURS	50	1	1,101				8
9	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	8	18,154		3	1,210	9
10	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	8	62,705		5	6,438	10
11	27	EMP BEN - NON OWNER CFO	WGHTD AVG HOURS	45	10	25,019		4	2,268	11
12	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	10	17,376		4	1,577	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					$ 281,899	$		$ 32,009	25

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			X	CONSTRUCTION MORTGAGE			$	$ 6,717,790			$ 84,071	1
2												2
3	RELATED PARTY										3,396	3
4	WOODBRIDGE NP	X		WORKING CAPITAL							24,584	4
5			X	INSURANCE FINANCING							675	5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL				350,000		4.2500	9,662	6
7	M.MAUER / M.AARON	X		WORKING CAPITAL				368,070			13,368	7
8	PHARMACY		X	PAYABLE FINANCING	$4,767.70	11/10/11	159,177	154,406	10/10/14	5.2500	841	8
9	TOTAL Facility Related				$4,767.70		$ 159,177	$ 7,590,266			$ 136,597	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 159,177	$ 7,590,266			$ 136,597	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # 36

*** 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 OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 36,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 36,798	2
3. Under or (over) accrual (line 2 minus line 1).		$ 798	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,000	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.		$ 38,798	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	59,885	8
	2007	59,153	9
	2008	61,997	10
	2009	35,552	11
	2010	36,798	12

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OTTAWA PAVILION LTD COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 00039230

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-13-111-001	NURSING HOME	$ 36,798.12	$ 36,798.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,798.12	$ 36,798.12

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation 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 a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,125 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	NURSING HOME		1998	$ 314,027	1
2					2
3	TOTALS			$ 314,027	3

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	119		1998		$ 1,567,864	$ 57,013	29	$ 57,013	$	$ 349,205	4
5											5
6											6
7											7
8	RELATED PARTY				38,142	978	35	1,090	112	19,979	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1994	13,015	333	39	333		5,807	9
10	WALLPAPER			1995	18,314	470	39	470		7,633	10
11	DRYWALL IN CORRIDOR			1995	17,550	450	39	450		7,331	11
12	HANDRAILS			1995	7,839	201	39	201		3,258	12
13	SECURITY DOOR			1995	1,602	41	39	41		658	13
14	MIXING VALVE & WATER HEATER			1995	756	19	39	19		305	14
15	HANDRAIL & BUMPER			1996	6,895	177	39	177		2,825	15
16	HANDRAIL & BUMPER			1996	721	18	39	18		382	16
17	ALARM			1996	1,146	29	39	29		447	17
18	PANIC DEVICE			1996	1,550	40	39	40		608	18
19	REPLACE RECONNECT SWITCH & STARTER			1996	1,074	28	39	28		423	19
20	DRAPERIES			1996	13,334	342	39	342		5,144	20
21	DRAPERY, CARPETING			1997	12,786	328	39	328		4,662	21
22	PIPING WORK, HEAT/COOL UNITS			1997	4,341	111	39	111		1,582	22
23	HEAT/COOL UNITS			1998	4,732	121	39	121		1,712	23
24	OFFICE REMODELING			1998	1,475	38	39	38		515	24
25	SHELVING/COOLER			1998	1,493	38	39	38		447	25
26	BOILER, HEAT/COOL UNIT			1999	10,441	268	39	268		3,453	26
27	ALARM SYSTEM			1999	2,853	73	39	73		946	27
28	WINDOWS			1999	19,785	507	39	507		5,929	28
29	FOLDING STEEL GATE			1999	884	23	39	23		277	29
30	REMODELING DISHWASHER ROOM			1999	5,000	128	39	128		1,541	30
31	DRAPERIES			1999	6,439	165	39	165		2,014	31
32	PARKING LOT PAVING			1999	1,834	47	39	47		592	32
33	BASEMENT REMODEL			2000	15,203	553	27.5	553		6,273	33
34	WINDOW REPAIR -- DOOR			2000	3,026	110	27.5	110		1,247	34
35	FEED PUMP -- HOT WATER VALVE			2000	4,131	150	27.5	150		1,703	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 OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	SPRINKLER SYSTEM REPAIR	2000	$ 1,175	$ 43	27.5	$ 43	$	$ 488	37
38	AIR CONDITIONER	2000	1,273	46	27.5	46		522	38
39	CARPETING -- SHEERS	2000	5,693		20	285	285	4,386	39
40	BASEMENT REMODEL	2001	20,088	730	27.5	730		7,650	40
41	BOILER/SPRINKLER REPAIRS	2001	10,031	365	27.5	365		3,823	41
42	BOILER REPAIR/PUMP/COMPRESSOR	2002	11,888	432	27.5	432		4,039	42
43	HEATER	2002	2,938	107	27.5	107		979	43
44	BASEMENT REMODEL	2002	18,705	680	27.5	680		6,437	44
45	BOILER REPAIR/PUMPS/CONDENSING UNIT	2003	9,701	353	27.5	353		2,986	45
46	SPRINKLER SYSTEM REPAIR	2003	16,320	593	27.5	593		6,016	46
47	DOOR CAMERAS AND LOCKS	2003	4,591	167	27.5	167		1,412	47
48	AIR CONDITIONER 5 TON	2003	1,960	71	27.5	71		598	48
49	SERVICE SINK	2003	802	29	27.5	29		245	49
50	WALL REPAIR - WATER DAMAGE	2003	1,370	50	27.5	50		423	50
51	PAINTING	2004	17,082	621	27.5	621		4,632	51
52	BOILER,CONDENSATE DRUMS & COMPRESSOR	2004	3,277	119	27.5	119		888	52
53	STAINLESS STEEL TOPS FOR TABLES	2004	1,065	39	27.5	39		290	53
54	EXHAUST DUCTS/HOOD & A/C COMPRESSOR	2005	2,789	101	27.5	101		653	54
55	ROOF	2005	30,875	1,123	27.5	1,123		7,253	55
56	FIRE PANEL FOR ALARM SYSTEM	2005	7,757	282	27.5	282		1,821	56
57	WATER TREATMENT, CONDENSER PUMP	2005	10,107	368	27.5	368		2,376	57
58	SPRINKLER HEADS	2006	1,862	68	27.5	68		371	58
59	CUBICLE CURTAINS	2006	1,267	46	27.5	46		251	59
60	AIR CONDITIONER	2006	1,349	49	27.5	49		268	60
61	PIPING & RELIEF VALVE FOR BOILER	2006	3,548	129	27.5	129		704	61
62	SUMP PUMP	2007	3,128	114	27.5	114		508	62
63	HEAT & AC UNITS	2007	1,804	65	27.5	65		290	63
64	FLAT RUBBER ROOF	2007	2,685	98	27.5	98		437	64
65	BOILER REPAIR	2007	2,301	84	27.5	84		374	65
66	WATER TREATMENT, CONDENSER PUMP	2008	9,909	360	27.5	360		1,245	66
67	GENERATOR, COMPRESSOR,BOILER	2008	12,431	452	27.5	452		1,563	67
68	DOORS, LIGHTS	2008	15,993	582	27.5	582		2,013	68
69	DINING ROOM -CARPET,TILE,WALLPAPER,CURTAINS	2008	25,855	940	27.5	940		3,151	69
70	TOTAL (lines 4 thru 69)		$ 2,045,844	$ 72,105		$ 72,502	$ 397	$ 505,990	70

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

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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		$ 2,045,844	$ 72,105		$ 72,502	$ 397	$ 505,990	1
2	HANDICAP RAMP REPLACEMENT	2008	3,100	113	27.5	113		391	2
3	COMPRESSOR - WATER COOLED CONDENSING UNIT	2009	2,263	82	27.5	82		202	3
4	WATER HEATER	2009	4,059	148	27.5	148		364	4
5	GENERATOR REPAIRS	2009	4,476	162	27.5	162		399	5
6	BOILER REPAIRS	2009	5,548	202	27.5	202		496	6
7	HEATING & COOLING UNITS	2009	1,347	49	27.5	49		120	7
8	REPLACE SMOKE DEDECTOR	2010	2,403	87	27.5	87		127	8
9	AIR CONDITIONERS	2010	1,417	52	27.5	52		76	9
10	ROOF WORK	2010	2,989	109	27.5	109		159	10
11	DOOR CLOSERS	2011	2,192	37	27.5	37		37	11
12	SIDEWALK REPLACEMENT	2011	1,133	38	15	38		38	12
13	POSIFLEX PERSONA URU SCANNER	2011	18,819	313	27.5	313		313	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)		$ 2,095,590	$ 73,497		$ 73,894	$ 397	$ 508,712	34

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

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 253,216	$ 11,367	$ 24,355	$ 12,988	5-10 YR	$ 139,540	71
72	Current Year Purchases	37,800	37,800	1,890	(35,910)	10 YR	1,890	72
73	Fully Depreciated Assets	121,221					121,221	73
74	RELATED PARTY	257,618	21,607	24,436	2,829		17,092	74
75	TOTALS	$ 669,855	$ 70,774	$ 50,681	$ (20,093)		$ 279,743	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	RELATED PARTY			$ 19,792	$ 944	$ 3,269	$ 2,325		$ 9,341	76
77										77
78										78
79										79
80	TOTALS			$ 19,792	$ 944	$ 3,269	$ 2,325		$ 9,341	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)	$ 3,099,264	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 145,215	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 127,844	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (17,371)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 797,796	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 OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 9,541 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2009 FORD E450	$ 578.00	$ 6,936	17
18					18
19					19
20					20
21	TOTAL		$ 578.00	$ 6,936	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 OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
   - [X] NO

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

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	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			58,572			58,572	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				193,718		193,718	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): SUPP/LAB/XRAY						14,205		14,205	13
14	TOTAL			$		$ 58,572	$ 207,923		$ 266,495	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 OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ 64,332	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,424,481		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,372		6
7	Other Prepaid Expenses	7,061		7
8	Accounts Receivable (owners or related parties)	326,680		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,895,926	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	489,584		15
16	Equipment, at Historical Cost	425,800		16
17	Accumulated Depreciation (book methods)	(552,680)		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): DEPOSIT	506		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 363,210	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,259,136	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 410,353	$	26
27	Officer's Accounts Payable	368,070		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	504,409		29
30	Accrued Salaries Payable	204,048		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,524		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,252		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,501,656	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,501,656	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 757,480	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,259,136	$	48

***(See instructions.)**

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (22,860)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (22,860)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	780,340	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 780,340	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)**	$ 757,480	24 *

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

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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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,379,487	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,379,487	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	371,671	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 371,671	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,959	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,959	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,753,117	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,043,679	31
32	Health Care	2,765,389	32
33	General Administration	1,425,781	33
	B. Capital Expense		
34	Ownership	406,280	34
	C. Ancillary Expense		
35	Special Cost Centers	266,495	35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,972,777	40
41	**Income before Income Taxes (line 30 minus line 40)****	780,340	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 780,340	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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.**

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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	1,784	1,968	$ 66,400	$ 33.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,958	8,261	241,789	29.27	3
4	Licensed Practical Nurses	23,010	26,007	534,775	20.56	4
5	CNAs & Orderlies	75,133	85,229	1,026,020	12.04	5
6	CNA Trainees					6
7	Licensed Therapist	14,334	18,196	516,392	28.38	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,006	2,749	31,423	11.43	9
10	Activity Assistants	9,346	9,793	101,400	10.35	10
11	Social Service Workers	2,051	2,131	32,037	15.03	11
12	Dietician					12
13	Food Service Supervisor	1,937	3,073	41,615	13.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,064	19,283	192,549	9.99	15
16	Dishwashers					16
17	Maintenance Workers	7,397	7,266	110,070	15.15	17
18	Housekeepers	13,030	14,896	140,075	9.40	18
19	Laundry	6,503	6,937	73,604	10.61	19
20	Administrator	2,101	3,155	80,766	25.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,179	4,574	68,588	15.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,074	5,501	80,951	14.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	193,907	219,019	$ 3,338,454 *	$ 15.24	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	M	$ 7,913	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,556	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,000	11-3	44
45	Social Service Consultant	E	2,000	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,469		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 768	10-3	50
51	Licensed Practical Nurses	784	31,963	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	800	$ 32,731		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARGIE LYLE	ADMINISTRATOR		$ 80,766
	ASST ADMIN		0
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,766

B. Administrative - Other

Description	Amount
MANAGEMENT FEE	$ 148,806
TOTAL (agree to Schedule V, line 17, col. 3)	$ 148,806
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		40,349
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 40,349

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 132,567
Unemployment Compensation Insurance	49,100
FICA Taxes	251,908
Employee Health Insurance	79,213
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	12,908
TOTAL (agree to Schedule V, line 22, col.8)	$ 525,696

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	$ 1,573
Advertising: Employee Recruitment	3,016
Health Care Worker Background Check	2,679
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	800
MARKETING/ADV/PROMO	43,353
LICENSES/DUES/SUBSCRIPTIONS	7,136
MGMT CO ALLOC	646
TRUST/FRANCHISE/CONTRIB/ETC	(800)
Less: Public Relations Expense	(0)
Non-allowable advertising	(43,353)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,050

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	691
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 691

**See instructions.

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number OTTAWA PAVILION LTD # 00039230 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica 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?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,987** Line **10-2**

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

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen during this cost report period. $ **65,153**
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 tc the Department, in addition to the daily rate, been properly classifiec 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 fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees