FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0039230

Facility Name: OTTAWA PAVILION

Address: 800 EAST 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		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: SANFORD BOKOR **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 01/01/2012 to 12/31/2012 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) SANFORD BOKOR, 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 # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	43,554	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	43,554	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			6,627	6,627	8
9	SNF/PED					9
10	ICF	18,235	7,238	302	25,775	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,235	7,238	6,929	32,402	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.40%

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 6,627

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: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	236,136	26,676	7,956	270,768		270,768		270,768			1
2	Food Purchase		207,265		207,265		207,265	(1,421)	205,844			2
3	Housekeeping	179,673	29,956		209,629		209,629		209,629			3
4	Laundry	66,314	18,517	1,823	86,654		86,654		86,654			4
5	Heat and Other Utilities			173,528	173,528		173,528	922	174,450			5
6	Maintenance	100,322	33,685	15,929	149,936		149,936	13,423	163,359			6
7	Other (specify):*			7,345	7,345		7,345	744	8,089			7
8	TOTAL General Services	582,445	316,099	206,581	1,105,125		1,105,125	13,668	1,118,793			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,980,002	69,874	23,725	2,073,601		2,073,601		2,073,601			10
10a	Therapy	538,168	1,500		539,668		539,668		539,668			10a
11	Activities	150,046	9,475	3,000	162,521		162,521		162,521			11
12	Social Services	32,703		1,103	33,806		33,806		33,806			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,700,919	80,849	33,828	2,815,596		2,815,596		2,815,596			16
	C. General Administration											
17	Administrative	84,364		79,000	163,364		163,364	82,080	245,444			17
18	Directors Fees											18
19	Professional Services			39,497	39,497		39,497	845	40,342			19
20	Dues, Fees, Subscriptions & Promotions			84,151	84,151		84,151	(69,414)	14,737			20
21	Clerical & General Office Expenses	78,202	32,633	398,980	509,815		509,815	(335,163)	174,652			21
22	Employee Benefits & Payroll Taxes			515,765	515,765		515,765		515,765			22
23	Inservice Training & Education			4,207	4,207		4,207		4,207			23
24	Travel and Seminar							2,132	2,132			24
25	Other Admin. Staff Transportation			18,463	18,463		18,463	(3,242)	15,221			25
26	Insurance-Prop.Liab.Malpractice			82,193	82,193		82,193		82,193			26
27	Other (specify):*			14,041	14,041		14,041	27,173	41,214			27
28	TOTAL General Administration	162,566	32,633	1,236,297	1,431,496		1,431,496	(295,589)	1,135,907			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,445,930	429,581	1,476,706	5,352,217		5,352,217	(281,921)	5,070,296			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 **#0039230** **Report Period Beginning: 01/01/2012** **Ending: 12/31/2012**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,956	
	REPAIRS & MAINTENANCE		0	
			0	7,956
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,823	
			0	1,823
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		39,127	
	ELECTRICITY		102,242	
	WATER		22,997	
	CABLE TV - LOBBY		9,162	
			0	173,528
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,151	
	PAINTING & DECORATING		823	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,272	
	ELEVATOR MAINTENANCE & REPAIR		3,452	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,231	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	15,929
7	**OTHER**			
	SCAVENGER		7,345	
	SECURITY SERVICE		0	
			0	
			0	7,345
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	17,467	
	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	6,258	
	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	23,725
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	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	1,103	
				1,103
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number OTTAWA PAVILION **#0039230** **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	79,000	79,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	17,735	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	21,762	
			0	39,497
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	68,789	
	EMPLOYEE WANT ADS	XIX F	2,920	
	CONTRIBUTIONS	VI 20 XIX F	200	
	DUES & SUBSCRIPTIONS	XIX F	4,790	
	LICENSES & PERMITS	XIX F	3,307	
	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	1,000	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,950	
	PATIENT BACKGROUND CHECKS	XIX F	1,195	
				84,151
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		8,868	
	EQUIPMENT REPAIR & MAINTENANCE		21,079	
	OUTSIDE CLERICAL SERVICES		354,900	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		14,133	
	MESSENGER SERVICE		0	
			0	398,980

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	260,596	
	UNEMPLOYMENT COMPENSATION	XIX D	68,913	
	WORKERS COMPENSATION INSURANC	XIX D	102,789	
	HOSPITALIZATION INSURANCE	XIX D	72,643	
	EMPLOYEE BENEFITS - OTHER	XIX D	10,824	
	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	515,765
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,207	
				4,207
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		18,463	
				18,463
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		82,193	
				82,193
27	**OTHER**			
	BAD DEBTS	VI 24	14,041	
				14,041

GRAND TOTAL COLUMN 3 OTHER **1,476,706**

OTTAWA PAVILION
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	207,265
LESS SALES TAX	(1,421)
NET FOOD	205,844
TOTAL PATIENT CENSUS	32,402
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	97,206
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	97,206
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	97,206
NET FOOD	205,844
DIVIDE TOTAL MEALS/YEAR	97,206
COST PER MEAL	2.12
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number OTTAWA PAVILION #0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			47,533	47,533		47,533	125,573	173,106			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,633	61,633		61,633	118,555	180,188			32
33	Real Estate Taxes							40,720	40,720			33
34	Rent-Facility & Grounds			378,000	378,000		378,000	(378,000)				34
35	Rent-Equipment & Vehicles			21,461	21,461		21,461	7,635	29,096			35
36	Other (specify):*											36
37	TOTAL Ownership			508,627	508,627		508,627	(85,517)	423,110			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		175,102		175,102		175,102		175,102			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,755	221,755		221,755		221,755			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		175,102	221,755	396,857		396,857		396,857			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,445,930	604,683	2,207,088	6,257,701		6,257,701	(367,438)	5,890,263			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 # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	(489,009)	30		9
10	Interest and Other Investment Income	(1,742)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,421)	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	(1,200)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(280)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,041)	27		24
25	Fund Raising, Advertising and Promotional	(68,789)	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	(37,141)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (613,623)		$	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)	246,185		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 246,185		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (367,438)		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

ID# 0039230

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (33,841)	21	1
2	MARKETING TRAVEL	(3,300)	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**	(37,141)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OTTAWA PAVILION # 0039230 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,421)	0	0	0	0	0	0	0	0	0	0	(1,421)	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	922	0	0	0	0	0	0	0	0	922	5
6	Maintenance	0	0	7,921	5,502	0	0	0	0	0	0	0	13,423	6
7	Other (specify):*	0	0	170	0	574	0	0	0	0	0	0	744	7
8	**TOTAL General Services**	(1,421)	0	9,013	5,502	574	0	0	0	0	0	0	13,668	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	(79,000)	0	161,080	0	0	0	0	0	0	0	82,080	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(280)	0	1,125	0	0	0	0	0	0	0	0	845	19
20	Fees, Subscriptions & Promotions	(69,989)	0	575	0	0	0	0	0	0	0	0	(69,414)	20
21	Clerical & General Office Expenses	(33,841)	(354,900)	46,404	7,174	0	0	0	0	0	0	0	(335,163)	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	2,132	0	0	0	0	0	0	0	0	2,132	24
25	Other Admin. Staff Transportation	(3,300)	0	58	0	0	0	0	0	0	0	0	(3,242)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(14,041)	0	8,951	0	32,263	0	0	0	0	0	0	27,173	27
28	**TOTAL General Administration**	(121,451)	(433,900)	59,245	168,254	32,263	0	0	0	0	0	0	(295,589)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(122,872)	(433,900)	68,258	173,756	32,837	0	0	0	0	0	0	(281,921)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OTTAWA PAVILION # 0039230 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(489,009)	612,253	2,329	0	0	0	0	0	0	0	0	125,573	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,742)	117,565	2,732	0	0	0	0	0	0	0	0	118,555	32
33	Real Estate Taxes	0	37,736	2,984	0	0	0	0	0	0	0	0	40,720	33
34	Rent-Facility & Grounds	0	(378,000)	0	0	0	0	0	0	0	0	0	(378,000)	34
35	Rent-Equipment & Vehicles	0	0	7,635	0	0	0	0	0	0	0	0	7,635	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(490,751)	389,554	15,680	0	0	0	0	0	0	0	0	(85,517)	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)	(613,623)	(44,346)	83,938	173,756	32,837	0	0	0	0	0	0	(367,438)	45

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		

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	$ 79,000	DYNAMIC HEALTH CARE CONSULTANTS		$	$ (79,000)	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	378,000	800 E. CENTER ST			(378,000)	7
8	V	30	DEPRECIATION		" "		612,253	612,253	8
9	V	32	INTEREST		" "		117,565	117,565	9
10	V	33	REAL ESTATE TAXES		" "		37,736	37,736	10
11	V								11
12	V								12
13	V								13
14	Total			$ 811,900			$ 767,554	$ * (44,346)	14

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$ 922	$ 922	15
16	V	6	REPAIR & MAINT.		" "		7,921	7,921	16
17	V	7	EMP BEN-GEN SERV		" "		170	170	17
18	V	19	PROFESSIONAL FEES		" "		1,125	1,125	18
19	V	20	DUES AND SUBSCRIPTION		" "		575	575	19
20	V	21	CLERICAL & GENERAL		" "		46,404	46,404	20
21	V	24	SEMINARS AND TRAVEL		" "		2,132	2,132	21
22	V	25	AUTO EXPENSE		" "		58	58	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" "		8,951	8,951	23
24	V	30	DEPRECIATION		" "		2,329	2,329	24
25	V	32	INTEREST		" "		2,732	2,732	25
26	V	33	REAL ESTATE TAXES		" "		2,984	2,984	26
27	V	35	EQUIPMENT RENTAL		" "		7,368	7,368	27
28	V	35	EQUIPMENT RENTAL		" "		267	267	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			$			$ 83,938	$ * 83,938	39

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$ 5,502	$ 5,502	15
16	V	17	ADMIN COMP - M MAUER		" "		16,492	16,492	16
17	V	17	ADMIN COMP - M AARON		" "		18,735	18,735	17
18	V	17	ADMIN COMP - F AARON		" "				18
19	V	17	ADMIN COMP - D AARON		" "				19
20	V	17	ADMIN COMP - S GOLDSTEIN		" "		38,282	38,282	20
21	V	17	ADMIN COMP - S HARAMARAS		" "				21
22	V	17	ADMIN COMP - D KUFTA		" "		14,243	14,243	22
23	V	17	ADMIN COMP - HOWARD ALTER		" "				23
24	V	17	ADMIN COMP - NON OWNER - V DAVIS		" "		41,195	41,195	24
25	V	17	ADMIN COMP - NON OWNER - VAR		" "		17,288	17,288	25
26	V	17	ADMIN COMP - NON OWNER - CFO		" "		14,845	14,845	26
27	V	21	CLERICAL COMP - S AARON		" "		7,043	7,043	27
28	V	21	CLERICAL COMP - E MARYLES		" "		131	131	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			$			$ 173,756	$ * 173,756	39

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$ 574	$ 574	15
16	V	27	EMP BEN - M MAUER		" "		894	894	16
17	V	27	EMP BEN - M AARON		" "		1,293	1,293	17
18	V	27	EMP BEN - F AARON		" "				18
19	V	27	EMP BEN - D AARON		" "				19
20	V	27	EMP BEN - S GOLDSTEIN		" "		14,186	14,186	20
21	V	27	EMP BEN - S HARAMARAS		" "				21
22	V	27	EMP BEN - D KUFTA		" "		999	999	22
23	V	27	EMP BEN - HOWARD ALTER		" "				23
24	V	27	EMP BEN - V DAVIS		" "		7,077	7,077	24
25	V	27	EMP BEN - NON OWNER		" "		4,634	4,634	25
26	V	27	EMP BEN - NON OWNER - CFO		" "		1,859	1,859	26
27	V	27	EMP BEN - S AARON		" "		1,309	1,309	27
28	V	27	EMP BEN - E MARYLES		" "		12	12	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			$			$ 32,837	$ * 32,837	39

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	MAURICE AARON	26.04	BRIDGEVIEW HEALTH CARE CENTER LTI	BRIDGEVIEW	800 E CENTER STREET		BUILDING CO	2
3	MARSHALL MAUER	14.70	GROSS POINTE MANOR LLC	NILES	DYNAMIC HEALTH	SKOKIE	BOOKKEEPING/C	3
4	SHIMON GOLDSTEIN	.84	PARK RIDGE CARE CENTER LTD	PARK RIDGE	SEASONS HOSPICE	PARK RIDGE	HOSPICE	4
5	FRED AARON	13.03	STERLING PAVILION LTD	STERLING				5
6	SUSIE ALTER	1.04	WARREN PARK HEALTH AND LIVING CEI	CHICAGO				6
7	SUSAN KOPLIN HARAMARAS	.53	WATERFRONT TERRACE INC	CHICAGO				7
8	DENNIS NEHMER	.53	WINDMILL NURSING PAVILION LTD	SOUTH HOLLAND				8
9	SHARON AARON	.53	WOODBRIDGE NURSING PAVILION LTD	CHICAGO				9
10	DIANA KUFTA	.53	WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				10
11	SYLVIA AARON	.21	WOODRIDGE SUPPORTING LIVING RESID	GENESEO				11
12	CHANA MAUER-RAY	5.67	WOODRIDGE SUPPORTIVE LIVING RESID	PONTIAC				12
13	ESTHER MAUER MARYLES	5.67						13
14	FRANCES MAUER	7.56						14
15	ABRAHAM STERN	15.54						15
16	DEVORA GOLDSTEIN	7.56						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 OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	MAURY AARON	SHAREHOLDER	ADMINISTRATIV	26.04	181,265	3.75	9.37	SALARY	$ 18,735	17-7	1
2	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIV	14.70	183,508	3.3	8.25	SALARY	16,492	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL	0.53	78,343	3.3	3.30	SALARY	7,043	21-7	3
4	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE	0.53	53,238	3.75	9.37	SALARY	5,502	6-7	4
5	DIANA KUFTA	SHAREHOLDER	ADMINISTRATIV	0.53	137,927	4.68	9.37	SALARY	14,243	17-7	5
6	S GOLDSTEIN	SHAREHOLDER	ADMINISTRATIV	0.84	63,804	15		SALARY	38,282	17-7	6
7	ESTHER MARYLES	SHAREHOLDER	CLERICAL	5.67	15,134	0.24	0.86	SALARY	131	21-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 100,428		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 # 0039230 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 STREET
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	PATIENT DAYS	413,728	13	$ 11,773	$	32,402	$ 922	1
2	6	REPAIR & MAINT.	PATIENT DAYS	413,728	13	101,134	34,519	32,402	7,921	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	413,728	13	2,165		32,402	170	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	413,728	13	14,369		32,402	1,125	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	413,728	13	7,338		32,402	575	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	413,728	13	592,509	421,664	32,402	46,404	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	413,728	13	27,227		32,402	2,132	7
8	25	AUTO EXPENSE	PATIENT DAYS	413,728	13	736		32,402	58	8
9	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	413,728	13	114,290		32,402	8,951	9
10	30	DEPRECIATION	PATIENT DAYS	413,728	13	29,732		32,402	2,329	10
11	32	INTEREST	PATIENT DAYS	413,728	13	34,887		32,402	2,732	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	413,728	13	38,096		32,402	2,984	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	94,085		32,402	7,368	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	3,415		32,402	267	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,071,756	$ 456,183		$ 83,938	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 STREET
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	$ 58,740	$ 58,740	4	$ 5,507	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	10	200,000	200,000	3	16,500	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	8	200,000	200,000	4	18,750	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	47,000	47,000			4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	52,765	52,765			5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	102,086	102,086	15	38,282	6
7	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	73,867	73,867			7
8	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	8	152,170	152,170	5	14,243	8
9	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			9
10	17	ADMIN COMP - NON OWNER - V I	WGHTD AVG HOURS	40	8	117,701	117,701	14	41,195	10
11	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	8	184,393	184,393	4	17,288	11
12	17	ADMIN COMP - NON OWNER - CH	WGHTD AVG HOURS	45	10	180,028	180,028	4	14,842	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	10	85,386	85,386	3	7,043	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	15,265	15,265	0	131	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,481,401	$ 1,481,401		$ 173,781	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 STREET
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	$ 6,127	$	4	$ 574	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	10	10,847		3	894	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	8	13,801		4	1,293	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	36,183				4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	4,278				5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,829		15	14,186	6
7	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	4	23,776				7
8	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	8	10,672		5	999	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,076				9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	8	20,219		14	7,077	10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	8	49,423		4	4,634	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	45	10	22,545		4	1,859	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	10	15,870		3	1,309	13
14	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	12	1,340		0	12	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 253,986	$		$ 32,837	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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				CONSTRUCTION MORTGAGE			$	$			$ 117,565	1
2												2
3	RELATED PARTY											3
4	RELATED PARTY			WORKING CAPITAL							25,000	4
5				INSURANCE FINANCING							170	5
	Working Capital											
6	MB FINANCIAL			WORKING CAPITAL				935,000			18,533	6
7	M.MAUER / M.AARON			WORKING CAPITAL				327,980			11,243	7
8	PHARMACY			PAYABLE FINANCING	$4,767.70	11/10/11	159,177	99,792			6,687	8
9	TOTAL Facility Related				$4,767.70		$ 159,177	$ 1,362,772			$ 179,198	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	$ 1,362,772			$ 179,198	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 # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 38,000	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.)		$ 37,736	2
3. Under or (over) accrual (line 2 minus line 1).		$ (264)	3
4. Real Estate Tax accrual used for 2012 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.		$ (264)	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	59,153	8
	2008	61,997	9
	2009	35,552	10
	2010	36,798	11
	2011	37,736	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 2011 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OTTAWA PAVILION COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0039230

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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-13-111-001	NURSING HOME	$ 37,735.80	$ 37,735.80
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 37,735.80	$ 37,735.80

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,354 B. General Construction Type: Exterior MASONRY Frame CONCRETE Number of Stories 1+BASEMENT

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	254,390	1998	$ 996,776	1
2					2
3	TOTALS	254,390		$ 996,776	3

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	17		1998		$ 550,000	$ 20,000	27.5	$ 20,000	$	$ 280,000	4
5	112			2012	14,324,575	119,610	27.5	119,610		119,610	5
6											6
7											7
8	RELATED PARTY				34,741	891	35	993	102	19,190	8
	Improvement Type**										
9	ROOF			2005	30,875	1,124	27.5	1,124		8,386	9
10	POSIFLEX PERSONA URU SCANNER			2011	18,819	315	27.5	315		1,003	10
11	CAPITALIZED CONSTRUCTION INTEREST			2012							11
12											12
13	SIGN			2012	4,243	142	15	142		142	13
14	ELECTRICAL, PUMP			2012	2,823	47	27.5	47		47	14
15	SPRINKLER/FIRE ALARM WORK			2012	4,881	82	27.5	82		82	15
16	CORNER GUARDS, LIGHTING, CURTAINS			2012	6,915	115	27.5	115		115	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 14,977,872	$ 142,326		$ 142,428	$ 102	$ 428,575	70

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$	$	$	$		$	71
72	Current Year Purchases	71,161	45,708	3,558	(42,150)		3,558	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	845,212	472,895	24,201	(448,694)		39,769	74
75	TOTALS	$ 916,373	$ 518,603	$ 27,759	$ (490,844)		$ 43,327	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			$ 19,651	$ 1,186	$ 2,919	$ 1,733		$ 5,544	76
77										77
78										78
79										79
80	TOTALS			$ 19,651	$ 1,186	$ 2,919	$ 1,733		$ 5,544	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)	$	16,910,672	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	662,115	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	173,106	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(489,009)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	477,446	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	NEW BUILDING	$ 675,369	92
93			93
94			94
95		$ 675,369	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 # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 14,525 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 # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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							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				159,372		159,372	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): SUPPLIES, XRAY,LAB						15,730		15,730	13
14	TOTAL			$		$	$ 175,102		$ 175,102	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 OTTAWA PAVILION **#** 0039230 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2012 **(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	$ 31,409	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 242,000)	1,774,659		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,285		6
7	Other Prepaid Expenses	2,726		7
8	Accounts Receivable (owners or related parties)	1,073,064		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,972,143	$	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	68,561		15
16	Equipment, at Historical Cost	71,161		16
17	Accumulated Depreciation (book methods)	(57,896)		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): DEPOSITS	24,892		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 106,718	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,078,861	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 413,800	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,034,792		29
30	Accrued Salaries Payable	241,240		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,310		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,556		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)**	$ 1,713,698	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	327,980		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)**	$ 327,980	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,041,678	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,037,183	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,078,861	$	48

***(See instructions.)**

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 753,091	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 753,091	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	284,092	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)**	$ 284,092	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,037,183	24 *

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 6,278,794	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,278,794	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	270,681	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 270,681	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***	1,742	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,742	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	LOSS ON SALE OF ASSETS	(9,424)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (9,424)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,541,793	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,105,125	31
32	Health Care	2,815,596	32
33	General Administration	1,431,496	33
	B. Capital Expense		
34	Ownership	508,627	34
	C. Ancillary Expense		
35	Special Cost Centers	175,102	35
36	Provider Participation Fee	221,755	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,257,701	40
41	**Income before Income Taxes (line 30 minus line 40)****	284,092	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 284,092	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,358,985	44
45	Private Pay - Net Inpatient Revenue	1,026,080	45
46	Medicare - Net Inpatient Revenue	2,800,048	46
47	Other-(specify) VETERAN	38,840	47
48	Other-(specify) HOSPICE	54,841	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,278,794	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.**

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

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	1,755	2,117	$ 69,722	$ 32.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,897	8,213	216,967	26.42	3
4	Licensed Practical Nurses	24,102	25,698	574,258	22.35	4
5	CNAs & Orderlies	75,187	80,452	1,041,569	12.95	5
6	CNA Trainees					6
7	Licensed Therapist	15,091	16,168	538,168	33.29	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,845	2,255	31,729	14.07	9
10	Activity Assistants	10,567	11,233	118,317	10.53	10
11	Social Service Workers	1,859	2,014	32,703	16.24	11
12	Dietician					12
13	Food Service Supervisor	2,065	2,283	42,970	18.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,665	18,034	193,166	10.71	15
16	Dishwashers					16
17	Maintenance Workers	6,390	6,919	100,322	14.50	17
18	Housekeepers	15,636	17,380	179,673	10.34	18
19	Laundry	5,673	6,263	66,314	10.59	19
20	Administrator	2,029	2,263	84,364	37.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,922	5,321	78,202	14.70	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	4,804	5,337	77,486	14.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	196,487	211,950	$ 3,445,930 *	$ 16.26	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	$ 7,956	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	6,258	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	1,103	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 24,317		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	64	$ 3,266	10-3	50
51	Licensed Practical Nurses	345	14,201	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	409	$ 17,467		53

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARGIE LYLE	ADMINISTRATOR		$ 84,364
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 84,364

B. Administrative - Other

Description	Amount
	$ 79,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 79,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		39,497
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 39,497

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,789
Unemployment Compensation Insurance	68,913
FICA Taxes	260,596
Employee Health Insurance	72,643
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	10,824
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 515,765

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	2,920
Health Care Worker Background Check	1,950
(Indicate # of checks performed)	
Patient Background Checks	1,195
TRUST/FRANCHISE/CONTRIB/ETC	1,200
MARKETING/ADV/PROMO	68,789
LICENSES/DUES/SUBSCRIPTIONS	8,097
MGMT CO ALLOC	575
TRUST/FRANCHISE/CONTRIB/ETC	(1,200)
Less: Public Relations Expense	(0)
Non-allowable advertising	(68,789)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,737

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	2,132
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,132

**See instructions.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 **#** 0039230 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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 political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(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. $ **12,980** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **221,755**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

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

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

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

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

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