FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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: 0039230

Facility Name: OTTAWA PAVILION

Address: 800 EAST CENTER ST (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: 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 01/01/2013 to 12/31/2013 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: 01/01/2013 Ending: 12/31/2013

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	1,294	4,700	8,653	14,647	8
9	SNF/PED					9
10	ICF	13,013	7,286	516	20,815	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,307	11,986	9,169	35,462	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.64%

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 8,003

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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	238,171	28,562	14,686	281,419		281,419		281,419			1
2	Food Purchase		221,535		221,535		221,535	(2,891)	218,644			2
3	Housekeeping	231,372	50,689		282,061		282,061		282,061			3
4	Laundry	62,261	23,189	1,284	86,734		86,734		86,734			4
5	Heat and Other Utilities			166,242	166,242		166,242	939	167,181			5
6	Maintenance	105,412	44,854	21,141	171,407		171,407	13,982	185,389			6
7	Other (specify):*			12,887	12,887		12,887	843	13,730			7
8	TOTAL General Services	637,216	368,829	216,240	1,222,285		1,222,285	12,873	1,235,158			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,354,528	82,538	21,781	2,458,847		2,458,847		2,458,847			10
10a	Therapy	509,509	3,655	23,836	537,000		537,000		537,000			10a
11	Activities	135,862	16,079	3,000	154,941		154,941		154,941			11
12	Social Services	48,914		1,248	50,162		50,162		50,162			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,048,813	102,272	55,865	3,206,950		3,206,950		3,206,950			16
	C. General Administration											
17	Administrative	86,170		80,000	166,170		166,170	57,885	224,055			17
18	Directors Fees											18
19	Professional Services			77,562	77,562		77,562	7,354	84,916			19
20	Dues, Fees, Subscriptions & Promotions			97,838	97,838		97,838	(83,170)	14,668			20
21	Clerical & General Office Expenses	98,120	32,912	410,480	541,512		541,512	(327,766)	213,746			21
22	Employee Benefits & Payroll Taxes			524,218	524,218		524,218		524,218			22
23	Inservice Training & Education			14,134	14,134		14,134		14,134			23
24	Travel and Seminar							748	748			24
25	Other Admin. Staff Transportation			18,984	18,984		18,984	(1,357)	17,627			25
26	Insurance-Prop.Liab.Malpractice			100,439	100,439		100,439	808	101,247			26
27	Other (specify):*			37,987	37,987		37,987	4,298	42,285			27
28	TOTAL General Administration	184,290	32,912	1,361,642	1,578,844		1,578,844	(341,200)	1,237,644			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,870,319	504,013	1,633,747	6,008,079		6,008,079	(328,327)	5,679,752			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: 01/01/2013** **Ending: 12/31/2013**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	14,686	
	REPAIRS & MAINTENANCE		0	
				14,686
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		678	
	OUTSIDE LABOR		606	1,284
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,008	
	ELECTRICITY		100,722	
	WATER		33,861	
	CABLE TV - LOBBY		6,651	
			0	166,242
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,029	
	PAINTING & DECORATING		1,241	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		8,600	
	ELEVATOR MAINTENANCE & REPAIR		1,050	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,221	
	FIRE SERVICE		0	
			0	
			0	
			0	
			0	21,141
7	**OTHER**			
	SCAVENGER		8,690	
	SECURITY SERVICE		4,197	
			0	
			0	12,887
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	14,510	
	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	7,271	
	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	21,781
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		9,576	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		14,260	
	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	
				23,836
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	1,248	
				1,248
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number OTTAWA PAVILION **#0039230** **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	80,000	80,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	34,229	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	43,333	
			0	77,562
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	83,599	
	EMPLOYEE WANT ADS	XIX F	3,671	
	CONTRIBUTIONS	VI 20 XIX F	300	
	DUES & SUBSCRIPTIONS	XIX F	2,007	
	LICENSES & PERMITS	XIX F	3,316	
	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	250	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,820	
	PATIENT BACKGROUND CHECKS	XIX F	1,875	
				97,838
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		13,593	
	EQUIPMENT REPAIR & MAINTENANCE		22,361	
	OUTSIDE CLERICAL SERVICES		357,900	
	PENALTIES / OVERDRAFT CHARGES	VI 18	834	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,792	
	MESSENGER SERVICE		0	
			0	410,480

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	294,534	
	UNEMPLOYMENT COMPENSATION	XIX D	61,880	
	WORKERS COMPENSATION INSURANC	XIX D	97,174	
	HOSPITALIZATION INSURANCE	XIX D	60,882	
	EMPLOYEE BENEFITS - OTHER	XIX D	9,748	
	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	524,218
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		14,134	
				14,134
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		18,984	
				18,984
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		100,439	
	INSURANCE CLAIM			
				100,439
27	**OTHER**			
	BAD DEBTS	VI 24	37,987	
				37,987

GRAND TOTAL COLUMN 3 OTHER **1,633,747**

OTTAWA PAVILION
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	221,535
LESS SALES TAX	(2,891)
NET FOOD	218,644
TOTAL PATIENT CENSUS	35,462
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	0
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	0
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	0
NET FOOD	218,644
DIVIDE TOTAL MEALS/YEAR	0
COST PER MEAL	0.00
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number OTTAWA PAVILION #0039230 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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			39,607	39,607		39,607	513,173	552,780			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			82,189	82,189		82,189	885,875	968,064			32
33	Real Estate Taxes							168,592	168,592			33
34	Rent-Facility & Grounds			1,180,150	1,180,150		1,180,150	(1,180,150)				34
35	Rent-Equipment & Vehicles			18,432	18,432		18,432	8,354	26,786			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,320,378	1,320,378		1,320,378	395,844	1,716,222			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		201,762		201,762		201,762		201,762			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	5,200			5,200		5,200		5,200			41
42	Provider Participation Fee			234,888	234,888		234,888		234,888			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	5,200	201,762	234,888	441,850		441,850		441,850			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,875,519	705,775	3,189,013	7,770,307		7,770,307	67,517	7,837,824			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: 01/01/2013 Ending: 12/31/2013

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	(121,466)	30		9
10	Interest and Other Investment Income	(1,210)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,891)	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	(834)	21		18
19	Entertainment		20		19
20	Contributions	(550)	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	(37,987)	27		24
25	Fund Raising, Advertising and Promotional	(83,599)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		10		28
29	Other-Attach Schedule	(4,468)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (253,005)		$	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)	320,522		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 320,522		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 67,517		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: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (35,544)	21	1
2	MARKETING TRAVEL	(3,300)	25	2
3	REAL ESTATE TAX ADJUSTMENT	34,376	33	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**	(4,468)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OTTAWA PAVILION # 0039230 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,891)	0	0	0	0	0	0	0	0	0	0	(2,891)	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	939	0	0	0	0	0	0	0	0	939	5
6	Maintenance	0	0	7,793	6,189	0	0	0	0	0	0	0	13,982	6
7	Other (specify):*	0	0	189	0	654	0	0	0	0	0	0	843	7
8	**TOTAL General Services**	(2,891)	0	8,921	6,189	654	0	0	0	0	0	0	12,873	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	(80,000)	0	137,885	0	0	0	0	0	0	0	57,885	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,341	2,013	0	0	0	0	0	0	0	0	7,354	19
20	Fees, Subscriptions & Promotions	(84,149)	0	979	0	0	0	0	0	0	0	0	(83,170)	20
21	Clerical & General Office Expenses	(36,378)	(357,900)	58,095	8,417	0	0	0	0	0	0	0	(327,766)	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	748	0	0	0	0	0	0	0	0	748	24
25	Other Admin. Staff Transportation	(3,300)	0	1,943	0	0	0	0	0	0	0	0	(1,357)	25
26	Insurance-Prop.Liab.Malpractice	0	0	808	0	0	0	0	0	0	0	0	808	26
27	Other (specify):*	(37,987)	0	10,853	0	31,432	0	0	0	0	0	0	4,298	27
28	**TOTAL General Administration**	(161,814)	(432,559)	75,439	146,302	31,432	0	0	0	0	0	0	(341,200)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(164,705)	(432,559)	84,360	152,491	32,086	0	0	0	0	0	0	(328,327)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OTTAWA PAVILION # 0039230 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	(121,466)	632,819	1,820	0	0	0	0	0	0	0	0	513,173	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,210)	884,203	2,882	0	0	0	0	0	0	0	0	885,875	32
33	Real Estate Taxes	34,376	130,592	3,624	0	0	0	0	0	0	0	0	168,592	33
34	Rent-Facility & Grounds	0	(1,180,150)	0	0	0	0	0	0	0	0	0	(1,180,150)	34
35	Rent-Equipment & Vehicles	0	0	8,354	0	0	0	0	0	0	0	0	8,354	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(88,300)	467,464	16,680	0	0	0	0	0	0	0	0	395,844	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)	(253,005)	34,905	101,040	152,491	32,086	0	0	0	0	0	0	67,517	45

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 80,000	DYNAMIC HEALTH CARE CONSULTANTS		$	$ (80,000)	1
2	V	21	BOOKKEEPING SERVICES	357,900	" "			(357,900)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	1,180,150	800 E. CENTER ST			(1,180,150)	7
8	V	30	DEPRECIATION		" "		632,819	632,819	8
9	V	32	INTEREST		" "		884,203	884,203	9
10	V	33	REAL ESTATE TAXES		" "		130,592	130,592	10
11	V	19	LEGAL & ACCOUNTING		" "		5,341	5,341	11
12	V								12
13	V								13
14	Total			$ 1,618,050			$ 1,652,955	$ * 34,905	14

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	BRADLEY	BRADLEY	800 E CENTER STREET		BUILDING CO	2
3	MARSHALL MAUER	14.70	BRIDGEVIEW HEALTH CARE CENTER LTI	NILES	DYNAMIC HEALTH CARE		BOOKKEEPING/C	3
4	SHIMON GOLDSTEIN	.84	GROSS POINTE MANOR LLC	PARK RIDGE	SEASONS HOSPICE		HOSPICE	4
5	FRED AARON	13.03	PARK RIDGE CARE CENTER LTD	STERLING				5
6	SUSIE ALTER	1.04	STERLING PAVILION LTD	CHICAGO				6
7	SUSAN KOPLIN HARAMARAS	.53	WARREN PARK HEALTH AND LIVING CEI	CHICAGO				7
8	DENNIS NEHMER	.53	WATERFRONT TERRACE INC	SOUTH HOLLAND				8
9	SHARON AARON	.53	WINDMILL NURSING PAVILION LTD	CHICAGO				9
10	DIANA KUFTA	.53	WOODBRIDGE NURSING PAVILION LTD	GALESBURG				10
11	SYLVIA AARON	.21	WOODRIDGE SUPPORTING LIVING RESID	GENESEO				11
12	CHANA MAUER-RAY	5.67	WOODRIDGE SUPPORTING LIVING RESID	PONTIAC				12
13	ESTHER MAUER MARYLES	5.67	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF P	PONTIAC				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: 01/01/2013 Ending: 12/31/2013

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		$ 939	$ 939	15
16	V	6	REPAIR & MAINT.		" "		7,793	7,793	16
17	V	7	EMP BEN-GEN SERV		" "		189	189	17
18	V	19	PROFESSIONAL FEES		" "		2,013	2,013	18
19	V	20	DUES AND SUBSCRIPTION		" "		979	979	19
20	V	21	CLERICAL & GENERAL		" "		58,095	58,095	20
21	V	24	SEMINARS AND TRAVEL		" "		748	748	21
22	V	25	AUTO EXPENSE		" "		1,943	1,943	22
23	V	26	INSURANCE		" "		808	808	23
24	V	27	EMP. BEN. - GEN, ADMIN.		" "		10,853	10,853	24
25	V	30	DEPRECIATION		" "		1,820	1,820	25
26	V	32	INTEREST		" "		2,882	2,882	26
27	V	33	REAL ESTATE TAXES		" "		3,624	3,624	27
28	V	35	EQUIPMENT RENTAL		" "		8,287	8,287	28
29	V	35	EQUIPMENT RENTAL		" "		67	67	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			$			$ 101,040	$ * 101,040	39

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 6,189	$ 6,189	15
16	V	17	ADMIN COMP - M MAUER		" "		18,347	18,347	16
17	V	17	ADMIN COMP - M AARON		" "		20,795	20,795	17
18	V	17	ADMIN COMP - F AARON		" "				18
19	V	17	ADMIN COMP - D AARON		" "				19
20	V	17	ADMIN COMP - S GOLDSTEIN		" "		33,900	33,900	20
21	V	17	ADMIN COMP - S HARAMARAS		" "				21
22	V	17	ADMIN COMP - D KUFTA		" "		16,436	16,436	22
23	V	17	ADMIN COMP - HOWARD ALTER		" "				23
24	V	17	ADMIN COMP - NON OWNER - V DAVIS		" "		10,838	10,838	24
25	V	17	ADMIN COMP - NON OWNER - VAR		" "		18,891	18,891	25
26	V	17	ADMIN COMP - NON OWNER - CFO		" "		18,678	18,678	26
27	V	21	CLERICAL COMP - S AARON		" "		7,953	7,953	27
28	V	21	CLERICAL COMP - E MARYLES		" "		464	464	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			$			$ 152,491	$ * 152,491	39

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 654	$ 654	15
16	V	27	EMP BEN - M MAUER		" "		1,006	1,006	16
17	V	27	EMP BEN - M AARON		" "		1,464	1,464	17
18	V	27	EMP BEN - F AARON		" "				18
19	V	27	EMP BEN - D AARON		" "				19
20	V	27	EMP BEN - S GOLDSTEIN		" "		15,394	15,394	20
21	V	27	EMP BEN - S HARAMARAS		" "				21
22	V	27	EMP BEN - D KUFTA		" "		1,157	1,157	22
23	V	27	EMP BEN - HOWARD ALTER		" "				23
24	V	27	EMP BEN - V DAVIS		" "		2,791	2,791	24
25	V	27	EMP BEN - NON OWNER		" "		5,733	5,733	25
26	V	27	EMP BEN - NON OWNER - CFO		" "		2,268	2,268	26
27	V	27	EMP BEN - S AARON		" "		1,581	1,581	27
28	V	27	EMP BEN - E MARYLES		" "		38	38	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			$			$ 32,086	$ * 32,086	39

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MAURY AARON	SHAREHOLDER	ADMINISTRATIVE			4.16	8.32	SALARY	$ 20,795	17-7	1
2	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIVE		SCHEDULE	3.67	7.34	SALARY	18,347	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL		ATTACHED	3.67	9.17	SALARY	7,953	21-7	3
4	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE			4.16	10.40	SALARY	6,189	6-7	4
5	DIANA KUFTA	SHAREHOLDER	ADMINISTRATIVE			5.2	10.40	SALARY	16,436	17-7	5
6	S GOLDSTEIN	SHAREHOLDER	ADMINISTRATIVE			15		SALARY	33,900	17-7	6
7	ESTHER MARYLES	SHAREHOLDER	CLERICAL			0.26	0.92	SALARY	464	21-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 104,084		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: 01/01/2013 Ending: 2/31/2013

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	407,371	12	$ 10,786	$	35,462	$ 939	1
2	6	REPAIR & MAINT.	PATIENT DAYS	407,371	12	89,523	37,553	35,462	7,793	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	407,371	12	2,175		35,462	189	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	407,371	12	23,130		35,462	2,013	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	407,371	12	11,247		35,462	979	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	407,371	12	667,372	493,233	35,462	58,095	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	407,371	12	8,593		35,462	748	7
8	25	AUTO EXPENSE	PATIENT DAYS	407,371	12	22,321		35,462	1,943	8
9	26	INSURANCE	PATIENT DAYS	407,371	12	9,284		35,462	808	9
10	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	407,371	12	124,673		35,462	10,853	10
11	30	DEPRECIATION	PATIENT DAYS	407,371	12	20,906		35,462	1,820	11
12	32	INTEREST	PATIENT DAYS	407,371	12	33,103		35,462	2,882	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	407,371	12	41,631		35,462	3,624	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	407,371	12	95,202		35,462	8,287	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	407,371	12	770		35,462	67	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,160,716	$ 530,786		$ 101,040	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	9	$ 59,522	$ 59,522	4	$ 6,189	1
2	6	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	4	18,347	2
3	7	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	9	200,000	200,000	4	20,795	3
4	19	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	12,500	12,500			4
5	20	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	60,271	60,271			5
6	21	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	90,400	90,400	15	33,900	6
7	24	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	75,862	75,862			7
8	25	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	9	158,070	158,070	5	16,436	8
9	27	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			9
10	30	ADMIN COMP - NON OWNER - V I	WGHTD AVG HOURS	40	11	118,147	118,147	4	10,838	10
11	32	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	9	181,559	181,559	5	18,891	11
12	33	ADMIN COMP - NON OWNER - CH	WGHTD AVG HOURS	40	11	203,618	203,618	4	18,678	12
13	35	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	11	86,700	86,700	4	7,953	13
14	35	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	50,541	50,541	0	464	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,509,190	$ 1,509,190		$ 152,491	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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	9	$ 6,291	$	4	$ 654	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	10,970		4	1,006	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	9	14,077		4	1,464	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	37,685				4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	4,884				5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	41,051		15	15,394	6
7	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	4	25,938				7
8	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	9	11,132		5	1,157	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,080				9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	11	30,426		4	2,791	10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	9	55,102		5	5,733	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	11	24,720		4	2,268	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	11	17,233		4	1,581	13
14	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	12	4,119		0	38	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 284,708	$		$ 32,086	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	CAMBRIDGE		X	MORTGAGE	$82,849.05	11/1/2010	$ 16,102,900	$ 16,033,961	10/1/2052	5.4500	$ 770,597	1
2												2
3												3
4	RELATED PARTY										2,882	4
5	RELATED PARTY	X		WORKING CAPITAL				1,111,667			150,689	5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL				1,000,000			32,014	6
7	M.MAUER / M.AARON	X		WORKING CAPITAL				285,571			8,914	7
8	PHARMACY		X	PAYABLE FINANCING				41,985			4,178	8
9	TOTAL Facility Related				$82,849.05		$ 16,102,900	$ 18,473,184			$ 969,274	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 16,102,900	$ 18,473,184			$ 969,274	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: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 83,592	2
3. Under or (over) accrual (line 2 minus line 1).		$ 83,592	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 85,000	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.		$ 168,592	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	61,997	8
	2009	35,552	9
	2010	36,798	10
	2011	37,736	11
	2012	83,592	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 2012 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OTTAWA PAVILION COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0039230

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-13-111-001	NURSING HOME	$ 83,591.82	$ 83,591.82
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,591.82	$ 83,591.82

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 01/01/2013 Ending: 12/31/2013

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	$ 1,806,939	1
2					2
3	TOTALS	254,390		$ 1,806,939	3

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$	39	$ 14,102	$ 14,102	$ 294,102	4
5	112			2012	15,834,469	361,596	39	361,596		508,803	5
6											6
7											7
8	RELATED PARTY				38,616	990	1103	35	(955)	22,434	8
	Improvement Type**										
9	ROOF			2005	30,875	1,123	27.5	1,123		9,509	9
10	POSIFLEX PERSONA URU SCANNER			2011	18,819	684	27.5	684		1,687	10
11	SIGN			2012	4,243	283	15	283		425	11
12	ELECTRICAL, PUMP			2012	2,823	106	27.5	106		153	12
13	SPRINKLER/FIRE ALARM WORK			2012	4,881	176	27.5	176		258	13
14	CORNER GUARDS, LIGHTING, CURTAINS			2012	6,915	250	27.5	250		365	14
15	MIXING VALVE& FAN MOTORS			2013	9,973	166	27.5	166		166	15
16	CORNER GUARDS			2013	1,837	30	27.5	30		30	16
17	PLUMBING WORK & SINKS			2013	3,352	56	27.5	56		56	17
18	ANTENNAS FOR PHONES			2013	1,675	27	27.5	27		27	18
19	SMOKE DETECTOR			2013	1,005	18	27.5	18		18	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: 01/01/2013 Ending: 12/31/2013

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)		$ 16,509,483	$ 365,505		$ 378,652	$ 13,147	$ 838,033	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: 01/01/2013 Ending: 12/31/2013

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	$ 57,603	$ 8,623	$ 5,760	$ (2,863)	10 YRS	$ 9,318	71
72	Current Year Purchases	54,280	28,065	5,428	(22,637)	10 YRS	5,428	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	1,599,459	271,428	158,550	(112,878)	10 YRS	176,487	74
75	TOTALS	$ 1,711,342	$ 308,116	$ 169,738	$ (138,378)		$ 191,233	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				$ 20,517	$ 625	$ 4,390	$ 3,765		$ 9,558	76
77										77
78										78
79										79
80	TOTALS			$ 20,517	$ 625	$ 4,390	$ 3,765		$ 9,558	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)	$ 20,048,281	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 674,246	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 552,780	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (121,466)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,038,824	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 # 0039230 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 11,496 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: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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				182,538		182,538	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Supplie, Lab,Radiology						19,224		19,224	13
14	TOTAL			$		$	$ 201,762		$ 201,762	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 # 0039230 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ 56,626	$ 62,454	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (50,000))	1,631,721	1,631,721	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,549	84,549	6
7	Other Prepaid Expenses	6,241	6,241	7
8	Accounts Receivable (owners or related parties)	1,355,898		8
9	Other(specify): ESCROWS & CLOSING COSTS		554,754	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,135,035	$ 2,339,719	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,806,939	13
14	Buildings, at Historical Cost		15,834,469	14
15	Leasehold Improvements, at Historical Cost	86,403	86,403	15
16	Equipment, at Historical Cost	125,441	1,704,418	16
17	Accumulated Depreciation (book methods)	(97,503)	(990,853)	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	28,342	28,342	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 142,683	$ 18,469,718	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,277,718	$ 20,809,437	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 687,129	$ 783,246	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,041,985	1,041,985	29
30	Accrued Salaries Payable	298,534	298,534	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,483	23,483	31
32	Accrued Real Estate Taxes(Sch.IX-B)		85,000	32
33	Accrued Interest Payable	10,608	83,559	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)**	$ 2,061,739	$ 2,315,807	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	285,571	2,033,912	39
40	Mortgage Payable		16,033,961	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)**	$ 285,571	$ 18,067,873	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,347,310	$ 20,383,680	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 930,408	$ 425,757	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,277,718	$ 20,809,437	48

***(See instructions.)**

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,032,590	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,032,590	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(102,182)	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)**	$ (102,182)	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)**	$ 930,408	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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,446,816	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,446,816	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	267,564	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 267,564	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	4,183	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)**	$ 4,183	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,210	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,210	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER	16,632	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,632	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,736,405	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,222,285	31
32	Health Care	3,206,950	32
33	General Administration	1,578,844	33
	B. Capital Expense		
34	Ownership	1,320,378	34
	C. Ancillary Expense		
35	Special Cost Centers	206,962	35
36	Provider Participation Fee	234,888	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	68,280	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,838,587	40
41	**Income before Income Taxes (line 30 minus line 40)****	(102,182)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (102,182)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,962,615	44
45	Private Pay - Net Inpatient Revenue	1,958,260	45
46	Medicare - Net Inpatient Revenue	3,344,579	46
47	Other-(specify) VETERAN	67,912	47
48	Other-(specify) HOSPICE	113,450	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,446,816	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: 01/01/2013 Ending: 12/31/2013

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	1,970	2,211	$ 76,444	$ 34.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,918	13,543	352,788	26.05	3
4	Licensed Practical Nurses	26,105	28,411	634,068	22.32	4
5	CNAs & Orderlies	88,129	95,764	1,204,808	12.58	5
6	CNA Trainees					6
7	Licensed Therapist	13,181	14,392	509,509	35.40	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,031	2,335	32,024	13.71	9
10	Activity Assistants	8,762	9,409	103,838	11.04	10
11	Social Service Workers	3,260	3,420	48,914	14.30	11
12	Dietician					12
13	Food Service Supervisor	2,082	2,475	43,429	17.55	13
14	Head Cook	1,184	1,210	11,716	9.68	14
15	Cook Helpers/Assistants	15,928	17,071	183,026	10.72	15
16	Dishwashers					16
17	Maintenance Workers	6,121	6,406	105,412	16.46	17
18	Housekeepers	19,831	21,939	231,372	10.55	18
19	Laundry	5,168	5,978	62,261	10.42	19
20	Administrator	1,951	2,262	86,170	38.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,270	7,776	98,120	12.62	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	5,372	6,204	86,420	13.93	31
32	Other Health Care(specify)					32
33	Other(specify) GIFT SHOP			5,200		33
34	TOTAL (lines 1 - 33)	221,263	240,806	$ 3,875,519 *	$ 16.09	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	360	$ 14,686	1-3	35
36	Medical Director		6,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		7,271	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	65	3,000	11-3	44
45	Social Service Consultant		1,248	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	425	$ 32,205		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	27	$ 1,226	10-3	50
51	Licensed Practical Nurses	326	13,284	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	352	$ 14,510		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARGIE LYLE	ADMINISTRATOR		$ 86,170
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 86,170

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 80,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 80,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		77,562
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 77,562

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,174
Unemployment Compensation Insurance	61,880
FICA Taxes	294,534
Employee Health Insurance	60,882
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	9,748
TOTAL (agree to Schedule V, line 22, col.8)	$ 524,218

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	$ 1,990
Advertising: Employee Recruitment	3,671
Health Care Worker Background Check	2,820
(Indicate # of checks performed)	
Patient Background Checks	1,875
TRUST/FRANCHISE/CONTRIB/ETC	550
MARKETING/ADV/PROMO	83,599
LICENSES/DUES/SUBSCRIPTIONS	3,333
MGMT CO ALLOC	979
TRUST/FRANCHISE/CONTRIB/ETC	(550)
Less: Public Relations Expense	(0)
Non-allowable advertising	(83,599)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,668

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	748
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 748

**See instructions.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	N/A												
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: 01/01/2013 Ending: 12/31/2013

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. $ **15,669** 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. $ **234,888**
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 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.