FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: 704 EAST GLOVER 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 01/01/2017 to 12/31/2017 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) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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: 01/01/2017 Ending: 12/31/2017

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	135	Skilled (SNF)	135	49,275	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	135	TOTALS	135	49,275	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			7,410	7,410	8
9	SNF/PED					9
10	ICF	18,434	15,642	1,172	35,248	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,434	15,642	8,582	42,658	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.57%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started _____

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

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified _____ and days of care provided 5,860

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	274,478	25,701	9,256	309,435		309,435		309,435			1
2	Food Purchase		292,015		292,015		292,015	(3,882)	288,133			2
3	Housekeeping	264,513	45,643		310,156		310,156		310,156			3
4	Laundry	57,643	13,384	1,809	72,836		72,836		72,836			4
5	Heat and Other Utilities			192,920	192,920		192,920	1,244	194,164			5
6	Maintenance	78,246	49,075	39,596	166,917		166,917	17,796	184,713			6
7	Other (specify):*			9,833	9,833		9,833	1,132	10,965			7
8	**TOTAL General Services**	674,880	425,818	253,414	1,354,112		1,354,112	16,290	1,370,402			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	3,140,004	139,979	70,150	3,350,133		3,350,133		3,350,133			10
10a	Therapy	755,088	6,612		761,700		761,700		761,700			10a
11	Activities	134,500	29,701	3,065	167,266		167,266		167,266			11
12	Social Services	40,761		799	41,560		41,560		41,560			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,070,353	176,292	80,014	4,326,659		4,326,659		4,326,659			16
	C. General Administration											
17	Administrative	106,777			106,777		106,777	194,152	300,929			17
18	Directors Fees											18
19	Professional Services			211,776	211,776		211,776	2,488	214,264			19
20	Dues, Fees, Subscriptions & Promotions			83,671	83,671		83,671	(40,740)	42,931			20
21	Clerical & General Office Expenses	150,577	40,407	729,234	920,218		920,218	(552,087)	368,131			21
22	Employee Benefits & Payroll Taxes			673,512	673,512		673,512		673,512			22
23	Inservice Training & Education			1,716	1,716		1,716		1,716			23
24	Travel and Seminar							417	417			24
25	Other Admin. Staff Transportation			6,931	6,931		6,931	4,267	11,198			25
26	Insurance-Prop.Liab.Malpractice			179,241	179,241		179,241	16,554	195,795			26
27	Other (specify):*	68,350		166,709	235,059		235,059	(101,961)	133,098			27
28	**TOTAL General Administration**	325,704	40,407	2,052,790	2,418,901		2,418,901	(476,910)	1,941,991			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,070,937	642,517	2,386,218	8,099,672		8,099,672	(460,620)	7,639,052			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: 01/01/2017** **Ending: 12/31/2017**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,256	
	REPAIRS & MAINTENANCE		0	
				9,256
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,809	
				1,809
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		18,043	
	ELECTRICITY		126,228	
	WATER		37,534	
	CABLE TV - LOBBY		11,115	
				192,920
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,540	
	PAINTING & DECORATING		469	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		27,714	
	ELEVATOR MAINTENANCE & REPAIR		4,531	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,342	
	FIRE SERVICE		0	
				39,596
7	**OTHER**			
	SCAVENGER		9,833	
	SECURITY SERVICE		0	
				9,833
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	59,032	
	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	11,118	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				70,150
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 CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	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	3,065	
				3,065
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	799	
				799
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number OTTAWA PAVILION **#0039230** **Report Period Beginning: 01/01/2017** **Ending: 12/31/2017**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	
				0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	102,108	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	109,668	
				211,776
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	45,221	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	6,259	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	19,367	
	LICENSES & PERMITS	XIX F	8,839	
	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	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	2,560	
	PATIENT BACKGROUND CHECKS	XIX F	1,425	
				83,671
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,609	
	EQUIPMENT REPAIR & MAINTENANCE		29,144	
	OUTSIDE CLERICAL SERVICES		675,606	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,815	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,060	
	MESSENGER SERVICE		0	
				729,234

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	380,943	
	UNEMPLOYMENT COMPENSATION	XIX D	60,283	
	WORKERS COMPENSATION INSURANC	XIX D	114,087	
	HOSPITALIZATION INSURANCE	XIX D	104,634	
	EMPLOYEE BENEFITS - OTHER	XIX D	13,565	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				673,512
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,716	
				1,716
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,931	
				6,931
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		179,241	
				179,241
27	**OTHER**			
	BAD DEBTS	VI 24	166,709	
				166,709

GRAND TOTAL COLUMN 3 OTHER **2,386,218**

OTTAWA PAVILION
SCHEDULES
12/31/2017

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

TOTAL FOOD PURCHASE	292,015
LESS SALES TAX	(3,882)
NET FOOD	288,133
TOTAL PATIENT CENSUS	42,658
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	127,974
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	49,275
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	127,974
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	127,974
NET FOOD	288,133
DIVIDE TOTAL MEALS/YEAR	127,974
COST PER MEAL	2.25
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number OTTAWA PAVILION #0039230 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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			37,413	37,413		37,413	570,057	607,470			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			99,359	99,359		99,359	648,278	747,637			32
33	Real Estate Taxes							180,230	180,230			33
34	Rent-Facility & Grounds			1,500,000	1,500,000		1,500,000	(1,500,000)				34
35	Rent-Equipment & Vehicles			45,971	45,971		45,971	15,669	61,640			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,682,743	1,682,743		1,682,743	(85,766)	1,596,977			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		184,074		184,074		184,074		184,074			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			289,429	289,429		289,429		289,429			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		184,074	289,429	473,503		473,503		473,503			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,070,937	826,591	4,358,390	10,255,918		10,255,918	(546,386)	9,709,532			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: 01/01/2017 Ending: 12/31/2017

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	(36,369)	30		9
10	Interest and Other Investment Income	(49,351)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,882)	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	(1,815)	21		18
19	Entertainment		20		19
20	Contributions		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	(166,709)	27		24
25	Fund Raising, Advertising and Promotional	(45,221)	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 SEE PG 5A				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (303,347)		$	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)	(243,039)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (243,039)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (546,386)		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: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OTTAWA PAVILION # 0039230 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,882)	0	0	0	0	0	0	0	0	0	0	(3,882)	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	1,244	0	0	0	0	0	0	0	0	1,244	5
6	Maintenance	0	0	9,662	8,134	0	0	0	0	0	0	0	17,796	6
7	Other (specify):*	0	0	253	0	879	0	0	0	0	0	0	1,132	7
8	**TOTAL General Services**	(3,882)	0	11,159	8,134	879	0	0	0	0	0	0	16,290	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	194,152	0	0	0	0	0	0	0	194,152	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,450	1,038	0	0	0	0	0	0	0	0	2,488	19
20	Fees, Subscriptions & Promotions	(45,221)	0	4,481	0	0	0	0	0	0	0	0	(40,740)	20
21	Clerical & General Office Expenses	(1,815)	(675,606)	115,907	9,427	0	0	0	0	0	0	0	(552,087)	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	417	0	0	0	0	0	0	0	0	417	24
25	Other Admin. Staff Transportation	0	0	4,267	0	0	0	0	0	0	0	0	4,267	25
26	Insurance-Prop.Liab.Malpractice	0	11,548	5,006	0	0	0	0	0	0	0	0	16,554	26
27	Other (specify):*	(166,709)	0	18,447	0	46,301	0	0	0	0	0	0	(101,961)	27
28	**TOTAL General Administration**	(213,745)	(662,608)	149,563	203,579	46,301	0	0	0	0	0	0	(476,910)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(217,627)	(662,608)	160,722	211,713	47,180	0	0	0	0	0	0	(460,620)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number OTTAWA PAVILION **#** 0039230 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(36,369)	602,931	3,495	0	0	0	0	0	0	0	0	570,057	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(49,351)	695,489	2,140	0	0	0	0	0	0	0	0	648,278	32
33	Real Estate Taxes	0	176,343	3,887	0	0	0	0	0	0	0	0	180,230	33
34	Rent-Facility & Grounds	0	(1,500,000)	0	0	0	0	0	0	0	0	0	(1,500,000)	34
35	Rent-Equipment & Vehicles	0	0	15,669	0	0	0	0	0	0	0	0	15,669	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(85,720)	(25,237)	25,191	0	0	0	0	0	0	0	0	(85,766)	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)**	(303,347)	(687,845)	185,913	211,713	47,180	0	0	0	0	0	0	(546,386)	45

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$	DYNAMIC HEALTH CARE CONSULTANTS		$	$	1
2	V	21	BOOKKEEPING SERVICES	675,606	" "			(675,606)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	1,500,000	800 E. CENTER ST			(1,500,000)	7
8	V	30	DEPRECIATION		" "		602,931	602,931	8
9	V	32	INTEREST		" "		695,489	695,489	9
10	V	33	REAL ESTATE TAXES		" "		176,343	176,343	10
11	V	19	LEGAL & ACCOUNTING		" "		1,450	1,450	11
12	V	26	INSURANCE				11,548	11,548	12
13	V								13
14	Total			$ 2,175,606			$ 1,487,761	$ * (687,845)	14

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	$ 1,244	$ 1,244	15
16	V	6	REPAIR & MAINT. - SALARIES		" "		3,773	3,773	16
17	V	6	EMP BEN-GEN SERV - OTHER		" "		5,889	5,889	17
18	V	7	EMP BEN-GEN SERV		" "		253	253	18
19	V	19	PROFESSIONAL FEES		" "		725	725	19
20	V	20	DUES AND SUBSCRIPTION		" "		4,481	4,481	20
21	V	21	CLERICAL & GENERAL - SALARIES		" "		82,679	82,679	21
22	V	21	CLERICAL & GENERAL - OTHER		" "		33,228	33,228	22
23	V	24	SEMINARS AND TRAVEL		" "		417	417	23
24	V	25	AUTO EXPENSE		" "		4,267	4,267	24
25	V	26	INSURANCE		" "		5,006	5,006	25
26	V	27	EMP. BEN. - GEN, ADMIN.		" "		18,447	18,447	26
27	V	30	DEPRECIATION		" "		3,495	3,495	27
28	V	32	INTEREST		" "		2,140	2,140	28
29	V	33	REAL ESTATE TAXES		" "		3,887	3,887	29
30	V	19	REAL ESTATE TAX PROTEST FEES		" "		313	313	30
31	V	35	AUTO RENTAL				15,026	15,026	31
32	V	35	EQUIPMENT RENTAL				643	643	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 185,913	$ * 185,913	39

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT COMP - D NEHMER	$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	$ 8,134	$ 8,134	15
16	V	17	ADMIN COMP - M MAUER		" "		24,149	24,149	16
17	V	17	ADMIN COMP - M AARON		" "		27,887	27,887	17
18	V	17	ADMIN COMP - F AARON		" "				18
19	V	17	ADMIN COMP - D AARON		" "		3,272	3,272	19
20	V	17	ADMIN COMP - S GOLDSTEIN		" "		37,875	37,875	20
21	V	17	ADMIN COMP - B FREIDMAN		" "				21
22	V	17	ADMIN COMP - R AARON		" "				22
23	V	17	ADMIN COMP - S HARAMARAS		" "				23
24	V	17	ADMIN COMP - D KUFTA		" "		20,612	20,612	24
25	V	17	ADMIN COMP - HOWARD ALTER		" "				25
26	V	17	ADMIN COMP - NON OWNER - V DAVIS		" "		16,158	16,158	26
27	V	17	ADMIN COMP - NON OWNER - CASSATA		" "				27
28	V	17	ADMIN COMP - NON OWNER - VAR		" "		35,214	35,214	28
29	V	17	ADMIN COMP - NON OWNER - CFO		" "		28,985	28,985	29
30	V	21	CLERICAL COMP - S AARON		" "		9,367	9,367	30
31	V	21	CLERICAL COMP - E MARYLES		" "		60	60	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 211,713	$ * 211,713	39

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP BEN - D NEHMER	$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	$ 879	$ 879	15
16	V	27	EMP BEN - M MAUER		" "		4,547	4,547	16
17	V	27	EMP BEN - M AARON		" "		5,797	5,797	17
18	V	27	EMP BEN - F AARON		" "				18
19	V	27	EMP BEN - D AARON		" "		331	331	19
20	V	27	EMP BEN - S GOLDSTEIN		" "		14,108	14,108	20
21	V	27	EMP BEN - B FREIDMAN		" "				21
22	V	27	EMP BEN - R AARON		" "				22
23	V	27	EMP BEN - S HARAMARAS		" "				23
24	V	27	EMP BEN - D KUFTA		" "		1,603	1,603	24
25	V	27	EMP BEN - HOWARD ALTER		" "				25
26	V	27	EMP BEN - V DAVIS		" "		4,334	4,334	26
27	V	27	EMP BEN - A CASSATA		" "				27
28	V	27	EMP BEN - NON OWNER		" "		9,564	9,564	28
29	V	27	EMP BEN - NON OWNER - CFO		" "		3,349	3,349	29
30	V	27	EMP BEN - S AARON		" "		2,239	2,239	30
31	V	27	EMP BEN - E MARYLES		" "		429	429	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 47,180	$ * 47,180	39

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	MAURICE AARON	26.04	BRADLEY	BRADLEY	800 E CENTER STREET		BUILDING CO	1
2	MARSHALL MAUER	14.7	BRIDGEVIEW HEALTH CARE CENTER LTI	BRIDGEVIEW	DYNAMIC HEALTH CARE		BOOKKEEPING/C	2
3	SHIMON GOLDSTEIN	.84	GROSS POINTE MANOR LLC	NILES	SEASONS HOSPICE		HOSPICE	3
4	FRED AARON	13.03	PARK RIDGE CARE CENTER LTD	PARK RIDGE				4
5	SUSIE ALTER	1.04	STERLING PAVILION LTD	STERLING				5
6	SUSAN KOPLIN HARAMARAS	.53	WATERFRONT TERRACE INC	CHICAGO				6
7	DENNIS NEHMER	.53	WILLOW CREST	CHICAGO				7
8	SHARON AARON	.53	WINDMILL NURSING PAVILION LTD	SOUTH HOLLAND				8
9	DIANA KUFTA	.53	WOODBRIDGE NURSING PAVILION LTD	CHICAGP				9
10	SYLVIA AARON	.21	WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				10
11	CHANA MAUER-RAY	5.67	WOODRIDGE SUPPORTING LIVING RESID	GENESEO				11
12	ESTHER MAUER MARYLES	5.67						12
13	FRANCES MAUER	7.56						13
14	ABRAHAM STERN	15.54						14
15	DEVORA GOLDSTEIN	7.56						15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	ADMINISTRATIVE			5.58	13.94	SALARY	$ 27,887	17-7	1
2	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIVE		SCHEDULE	4.83	12.07	SALARY	24,149	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL		ATTACHED	4.83	12.07	SALARY	9,367	21-7	3
4	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE			5.58	13.94	SALARY	8,134	6-7	4
5	DIANA KUFTA	SHAREHOLDER	ADMINISTRATIVE			5.58	13.94	SALARY	20,612	17-7	5
6	S GOLDSTEIN	SHAREHOLDER	ADMINISTRATIVE			15		SALARY	51,555	17-7	6
7	ESTHER MARYLES	SHAREHOLDER	CLERICAL			0.34	1.21	SALARY	60	21-7	7
8	DANIEL AARON		ADMINISTRATIVE			1.71	4.28	SALARY	3,272	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 145,036		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: 01/01/2017 Ending: 2/31/2017

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	371,884	371884	$ 10,844	$	42,658	$ 1,244	1
2	6	REPAIR & MAINT. - SALARIES	PATIENT DAYS	371,884	371884	32,891	32,891	42,658	3,773	2
3	6	REPAIR & MAINT. - OTHER	PATIENT DAYS	371,884	371884	51,340		42,658	5,889	3
4	7	EMP BEN-GEN SERV	PATIENT DAYS	371,884	371884	2,209		42,658	253	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	371,884	371884	6,316		42,658	725	5
6	20	DUES AND SUBSCRIPTION	PATIENT DAYS	371,884	371884	39,064		42,658	4,481	6
7	21	CLERICAL & GENERAL - SALARI	PATIENT DAYS	371,884	371884	720,780	720,780	42,658	82,679	7
8	21	CLERICAL & GENERAL - OTHER	PATIENT DAYS	371,884	371884	289,675		42,658	33,228	8
9	24	SEMINARS AND TRAVEL	PATIENT DAYS	371,884	371884	3,633		42,658	417	9
10	25	AUTO EXPENSE	PATIENT DAYS	371,884	371884	37,201		42,658	4,267	10
11	26	INSURANCE	PATIENT DAYS	371,884	371884	43,644		42,658	5,006	11
12	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	371,884	371884	160,819		42,658	18,447	12
13	30	DEPRECIATION	PATIENT DAYS	371,884	371884	30,466		42,658	3,495	13
14	32	INTEREST	PATIENT DAYS	371,884	371884	18,656		42,658	2,140	14
15	33	REAL ESTATE TAXES	PATIENT DAYS	371,884	371884	33,889		42,658	3,887	15
16	19	REAL ESTATE TAX PROTEST FEI	PATIENT DAYS	371,884	371884	2,725		42,658	313	16
17	35	AUTO RENTAL	PATIENT DAYS	371,884	371884	130,997		42,658	15,026	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	371,884	371884	5,607		42,658	643	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,620,756	$ 753,671		$ 185,913	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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	7	$ 58,337	$ 58,337	6	$ 8,134	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	5	24,149	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	7	200,000	200,000	6	27,887	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	2,500	2,500			4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	11	76,541	76,541	2	3,272	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	101,000	101,000	15	37,875	6
7	17	ADMIN COMP - B FREIDMAN	WGHTD AVG HOURS							7
8	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	40	1	61,541	61,541			8
9	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	3	71,909	71,909			9
10	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	7	147,753	147,753	6	20,612	10
11	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			11
12	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	9	133,816	133,816	5	16,158	12
13	17	ADMIN COMP - NON OWNER - A	WGHTD AVG HOURS							13
14	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	7	252,333	252,333	6	35,214	14
15	17	ADMIN COMP - NON OWNER - CF	WGHTD AVG HOURS	40	9	240,048	240,048	5	28,985	15
16	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	77,614	77,614	5	9,367	16
17	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	11	5,000	5,000	0	60	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,640,392	$ 1,640,392		$ 211,713	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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	7	$ 6,305	$	6	$ 879	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	37,655		5	4,547	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	7	41,575		6	5,797	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	42,544				4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	11	7,737		2	331	5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,621		15	14,108	6
7	27	EMP BEN - B FREIDMAN	WGHTD AVG HOURS							7
8	27	EMP BEN - R AARON	WGHTD AVG HOURS	40	1	27,046				8
9	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	3	28,711				9
10	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	40	7	11,492		6	1,603	10
11	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,095				11
12	27	EMP BEN - NON OWNER - V DAVI	WGHTD AVG HOURS	40	9	35,890		5	4,334	12
13	27	EMP BEN - NON OWNER - A CASS	WGHTD AVG HOURS							13
14	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	7	68,533		6	9,564	14
15	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	9	27,736		5	3,349	15
16	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	9	18,548		5	2,239	16
17	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	11	35,535		0	429	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 428,023	$		$ 47,180	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	CAMBRIDGE		X	MORTGAGE	$82,849.05	11/2/2010	$ 16,102,900	$ 15,406,853	10/1/2052	5.4500	$ 695,489	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL				747,854			48,901	6
7	RELATED PARTY	X		WORKING CAPITAL				1,027,500			50,458	7
8												8
9	TOTAL Facility Related				$82,849.05		$ 16,102,900	$ 17,182,207			$ 794,848	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	$ 17,182,207			$ 794,848	15

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

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

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 179,000	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.)		$ 179,730	2
3. Under or (over) accrual (line 2 minus line 1).		$ 730	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 179,500	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.		$ 180,230	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	83,592	8
	2013	124,901	9
	2014	165,335	10
	2015	175,323	11
	2016	179,730	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 2016 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-13-111-001	NURSING HOME	$ 175,843.22	$ 175,843.22
2.			$	$
3.		RELATED PARTY	$	$ 3,887.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 175,843.22	$ 179,730.22

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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	$ 14,106	$ 14,106	$ 350,523	4
5	118				15,864,469		39	412,070	412,070	2,155,750	5
6											6
7	RELATED PARTY				50,884		35	1,454	1,454	35,376	7
8											8
	Improvement Type**										
9	ROOF			2005	30,875		39	791	791	13,005	9
10	POSIFLEX PERSONA URU SCANNER			2011	18,819		39	482	482	3,817	10
11	SIGN			2012	4,243		15	283	283	1,557	11
12	ELECTRICAL, PUMP			2012	2,823		39	72	72	475	12
13	SPRINKLER/FIRE ALARM WORK			2012	4,881		39	125	125	809	13
14	CORNER GUARDS, LIGHTING, CURTAINS			2012	6,915		39	178	178	1,149	14
15	MIXING VALVE& FAN MOTORS			2013	9,973		39	256	256	1,100	15
16	CORNER GUARDS			2013	1,837		39	47	47	201	16
17	PLUMBING WORK & SINKS			2013	3,352		39	85	85	367	17
18	ANTENNAS FOR PHONES			2013	1,675		39	43	43	183	18
19	SMOKE DETECTOR			2013	1,005		39	26	26	114	19
20	HEAT PUMP, AC REPAIR, BOOSTER PUMP			2015	14,715		39	366	366	921	20
21	WALK IN COOLER REPAIR			2015	4,083		39	106	106	264	21
22	SIGNAGE			2015	2,479		39	63	63	158	22
23	LED HDTV, JUMBO BUTTON REMOTE CONTROLS			2015	1,047		39	28	28	69	23
24	DISPOSER			2015	2,574		39	71	71	175	24
25	PARKING LOT SEAL & STRIPE			2015	2,617		39	71	71	176	25
26	HEAT PUMP			2016	982		39	25	25	50	26
27	DOOR CLOSERS			2016	1,294		39	28	28	56	27
28	AIR DUCT & FIRE DAMPERS			2016	5,986		39	66	66	132	28
29	PARKING LOT SEAL & STRIPE			2016	2,342		39	39	39	78	29
30	RIVER ROCK			2016	1,193		39	20	20	40	30
31	NURSE CALL LIGHT			2016	2,732		39	12	12	24	31
32	SPRINKLER SYSTEM REPAIR			2017	8,227		39	105	105	210	32
33	AC CONDENSOR			2017	7,400		39	95	95	190	33
34	ELECTRICAL OUTLETS/CALL LIGHT BOX			2017	7,400		39	95	95	190	34
35	DOOR CLOSERS			2017	1,768		39	23	23	46	35
36	ROOF REPAIR			2017	3,800		39	49	49	98	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: 01/01/2017 Ending: 12/31/2017

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	BOOK DEPRECIATION			643,839			(643,839)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 16,622,390	$ 643,839		$ 431,280	$ (212,559)	$ 2,567,303	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: 01/01/2017 Ending: 12/31/2017

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	$ 200,685	$	$ 20,068	$ 20,068	10	$ 80,936	71
72	Current Year Purchases	35,571		1,779	1,779	10	1,779	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	1,551,616		152,915	152,915			74
75	TOTALS	$ 1,787,872	$	$ 174,762	$ 174,762		$ 82,715	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			$ 33,958	$	$ 1,428	$ 1,428		$ 27,035	76
77										77
78										78
79										79
80	TOTALS			$ 33,958	$	$ 1,428	$ 1,428		$ 27,035	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)	$ 20,251,159	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 643,839	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 607,470	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (36,369)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,677,053	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: 01/01/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 34,599 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		2014 CHEVY CRUZE	$ 248.00	$ 8,448	17
18			704.00	2,924	18
19					19
20					20
21	TOTAL		$ 952.00	$ 11,372	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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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				165,201		165,201	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify): MED SUPPLIES,	39-2					18,873		18,873	13
14	TOTAL			$		$	$ 184,074		$ 184,074	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:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ 152,988	$ 346,952	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (199,000))	1,399,206	1,399,206	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	137,891	210,585	6
7	Other Prepaid Expenses	9,378	9,378	7
8	Accounts Receivable (owners or related parties)	1,810,895	18,323	8
9	Other(specify): ESCROWS		639,676	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,510,358	$ 2,624,120	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		15,864,469	14
15	Leasehold Improvements, at Historical Cost	158,590	158,590	15
16	Equipment, at Historical Cost	249,818	1,770,745	16
17	Accumulated Depreciation (book methods)	(195,505)	(3,833,413)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		130,026	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(13,672)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSITS	24,892	24,892	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 237,795	$ 15,908,576	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,748,153	$ 18,532,696	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 566,534	$ 566,534	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	742,178	742,178	29
30	Accrued Salaries Payable	427,865	427,865	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,262	22,262	31
32	Accrued Real Estate Taxes(Sch.IX-B)		179,500	32
33	Accrued Interest Payable	1,676	59,323	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)**	$ 1,760,515	$ 1,997,662	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,406,853	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	MORTGAGE PREMIUM NET		1,129,995	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 16,536,848	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,760,515	$ 18,534,510	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,987,638	$ (1,814)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,748,153	$ 18,532,696	48

***(See instructions.)**

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,183,626	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(11,770)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,171,856	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	115,782	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	(300,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (184,218)	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)**	$ 1,987,638	24 *

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 10,185,412	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,185,412	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	247,501	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 247,501	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	4,480	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	222	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)**	$ 4,702	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	49,351	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 49,351	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER	16,315	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,315	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,503,281	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,354,112	31
32	Health Care	4,326,659	32
33	General Administration	2,418,901	33
	B. Capital Expense		
34	Ownership	1,682,743	34
	C. Ancillary Expense		
35	Special Cost Centers	184,074	35
36	Provider Participation Fee	289,429	36
	D. Other Expenses (specify):		
37	PRIOR PERIOD EXPENSE	131,581	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,387,499	40
41	**Income before Income Taxes (line 30 minus line 40)****	115,782	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 115,782	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,747,886	44
45	Private Pay - Net Inpatient Revenue	3,587,810	45
46	Medicare - Net Inpatient Revenue	3,819,712	46
47	Other-(specify) INSURANCE	30,004	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,185,412	49

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

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

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

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	1,832	$ 85,000	$ 46.40	1
2	Assistant Director of Nursing	2,264	2,108	68,979	32.72	2
3	Registered Nurses	15,674	14,954	447,073	29.90	3
4	Licensed Practical Nurses	29,908	28,319	737,966	26.06	4
5	CNAs & Orderlies	124,809	116,946	1,656,772	14.17	5
6	CNA Trainees					6
7	Licensed Therapist	19,312	17,999	712,509	39.59	7
8	Rehab/Therapy Aides	2,066	1,967	42,579	21.65	8
9	Activity Director	2,328	2,143	37,699	17.59	9
10	Activity Assistants	10,006	9,476	96,801	10.22	10
11	Social Service Workers	2,115	1,875	40,761	21.74	11
12	Dietician					12
13	Food Service Supervisor	4,247	3,884	73,018	18.80	13
14	Head Cook	4,392	3,858	53,158	13.78	14
15	Cook Helpers/Assistants	14,225	13,331	148,302	11.12	15
16	Dishwashers					16
17	Maintenance Workers	4,743	4,317	78,246	18.13	17
18	Housekeepers	24,890	22,623	264,513	11.69	18
19	Laundry	4,990	4,582	57,643	12.58	19
20	Administrator	2,338	2,199	106,777	48.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	585	489	11,032	22.56	23
24	Clerical	8,985	7,801	139,545	17.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,064	895	11,872	13.26	31
32	Other Health C: Care Plan Supervi	4,121	3,671	132,342	36.05	32
33	Other(specify) Admitting,social sv	4,379	3,949	68,350	17.31	33
34	TOTAL (lines 1 - 33)	289,521	269,218	$ 5,070,937 *	$ 18.84	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	$ 9,256	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	11,118	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	3,065	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) Social Work Consulta	S	799	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 30,238		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 59,032	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$ 59,032		53

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOHN RAGSDALE	ADMINISTRATOR		$ 106,777
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 106,777

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED		211,776
SEE LEGAL SCHEDULE ATTACHED		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 211,776

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 114,087
Unemployment Compensation Insurance	60,283
FICA Taxes	380,943
Employee Health Insurance	104,634
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	13,565
TOTAL (agree to Schedule V, line 22, col.8)	$ 673,512

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	6,259
Health Care Worker Background Check	2,560
(Indicate # of checks performed)	
Patient Background Checks	1,425
TRUST/FRANCHISE/CONTRIB/ETC	0
MARKETING/ADV/PROMO	45,221
LICENSES/DUES/SUBSCRIPTIONS	26,216
MGMT CO ALLOC	4,481
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(45,221)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,931

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
MGMT CO ALLOC	417
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 417

**See instructions.

OTTAWA PAVILION
Legal Fee Schedule

DATE	NAME	DESCRIPTION	AMOUNT
3/1/2017	MUCH SHELIST	GENERAL COUNSELING	154.00
4/1/2017	MUCH SHELIST	GENERAL COUNSELING	2,258.62
5/1/2017	MUCH SHELIST	GENERAL COUNSELING	1,190.50
8/1/2017	MUCH SHELIST	GENERAL COUNSELING	654.50
9/1/2017	MUCH SHELIST	GENERAL COUNSELING	242.97
10/23/2017	MUCH SHELIST	GENERAL COUNSELING	350.00
2/28/2017	SIMANDL LAW GROUP	FACILITY AUDITS	31.92
1/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	320.00
2/28/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	337.05
3/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,110.00
4/30/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	602.50
5/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,239.00
6/30/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	150.53
7/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	82.83
8/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	140.00
9/30/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	64.38
10/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	42.90
11/30/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	90.00
12/31/2017	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	180.00
7/12/2017	VON BRIESEN & ROPER	EMPLOYEE ARBITRATION	1,625.50
8/15/2017	VON BRIESEN & ROPER	EMPLOYEE ARBITRATION	4,723.50
9/14/2017	VON BRIESEN & ROPER	EMPLOYEE ARBITRATION	67.00
11/14/2017	VON BRIESEN & ROPER	EMPLOYEE ARBITRATION	16,950.00
12/18/2017	VON BRIESEN & ROPER	EMPLOYEE ARBITRATION	449.73
12/18/2017	VON BRIESEN & ROPER	EMPLOYEE ARBITRATION	11,959.50
12/18/2017	VON BRIESEN & ROPER	LABOR & EMPLOYMENT	268.00
12/18/2017	VON BRIESEN & ROPER	EMPLOYEE ARBITRATION	16,984.50
10/11/2017	LAW OFFICES FIELD AND GOLDBERG	GENERAL LITIGATION	907.00
			63,176.43

Facility Name & ID Number OTTAWA PAVILION **#** 0039230 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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? **YES**
If YES, give association name and amount. **ICLTC $12,352**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(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. $ **25,184** 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. $ **289,429**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.