FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 LTD

Address: 704 EAST GLOVER STREET (Number) OTTAWA (City) 61350 (Zip Code)

County: LASALLE

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

HFS ID Number:

Date of Initial License for Current Owners: 12/010/1993

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: KATHLEEN MCNAMARA **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 01/01/2018 to 12/31/2018 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) KATHLEEN MCNAMARA, VICE-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 LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			7,456	7,456	8
9	SNF/PED					9
10	ICF	19,440	17,181		36,621	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,440	17,181	7,456	44,077	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.45%

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 12/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 135 and days of care provided 7,456

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	291,898	26,071	9,793	327,762		327,762		327,762			1
2	Food Purchase		296,928		296,928	(7,884)	289,044	(3,558)	285,486			2
3	Housekeeping	266,573	54,604		321,177		321,177		321,177			3
4	Laundry	59,134	13,627	2,906	75,667		75,667		75,667			4
5	Heat and Other Utilities			202,506	202,506		202,506	1,536	204,042			5
6	Maintenance	79,637	44,055	28,843	152,535		152,535	19,472	172,007			6
7	Other (specify):*			10,919	10,919		10,919	1,045	11,964			7
8	**TOTAL General Services**	697,242	435,285	254,967	1,387,494	(7,884)	1,379,610	18,495	1,398,105			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	3,702,401	148,532	35,361	3,886,294		3,886,294		3,886,294			10
10a	Therapy	800,964	3,975		804,939		804,939		804,939			10a
11	Activities	157,029	19,298	2,487	178,814		178,814		178,814			11
12	Social Services	49,266		884	50,150		50,150		50,150			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,709,660	171,805	44,732	4,926,197		4,926,197		4,926,197			16
	C. General Administration											
17	Administrative	107,272			107,272		107,272	230,476	337,748			17
18	Directors Fees											18
19	Professional Services			174,864	174,864		174,864	17,831	192,695			19
20	Dues, Fees, Subscriptions & Promotions			114,021	114,021		114,021	(65,206)	48,815			20
21	Clerical & General Office Expenses	131,377	30,336	836,949	998,662		998,662	(634,519)	364,143			21
22	Employee Benefits & Payroll Taxes			761,513	761,513	7,884	769,397		769,397			22
23	Inservice Training & Education			4,867	4,867		4,867		4,867			23
24	Travel and Seminar			10,777	10,777		10,777	715	11,492			24
25	Other Admin. Staff Transportation							7,479	7,479			25
26	Insurance-Prop.Liab.Malpractice			214,682	214,682		214,682	18,358	233,040			26
27	Other (specify):*	52,410		67,391	119,801		119,801	16,474	136,275			27
28	**TOTAL General Administration**	291,059	30,336	2,185,064	2,506,459	7,884	2,514,343	(408,392)	2,105,951			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,697,961	637,426	2,484,763	8,820,150		8,820,150	(389,897)	8,430,253			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: OTTAWA PAVILION LTD #0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,793	
	REPAIRS & MAINTENANCE			
				9,793
3	**HOUSEKEEPING**			
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,906	
				2,906
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		17,608	
	ELECTRICITY		137,046	
	WATER		36,426	
	CABLE TV - LOBBY		11,426	
				202,506
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,662	
	PAINTING & DECORATING		233	
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL			
	EQUIPMENT MAINTENANCE & REPAIR		17,934	
	ELEVATOR MAINTENANCE & REPAIR		4,672	
	OUTSIDE LABOR			
	EXTERMINATING SERVICE		3,342	
	FIRE SERVICE			
				28,843
7	**OTHER**			
	SCAVENGER		10,919	
	SECURITY SERVICE			
				10,919
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		
	LABORATORY & XRAY EXPENSE			
	PURCHASED SERVICES			
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2		
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2		
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2		
	PHARMACY CONSULTANT	XVIII B 39-2	16,602	
	UTILIZATION REVIEW FEES	XVIII B __-2		
	PHYSICIANS	XVIII B __-2		
	PSYCHIATRIC	XVIII B __-2		
	RN CONSULTANT	XVIII B 38-2	6,759	
	CARDIOLOGIST CONSULTANT		6,000	
	NURSING PROGRAM CONSULTANT		6,000	35,361
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES			
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2		
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2		
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2		
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2		
	SPEECH THERAPY CONSULTANT	XVIII B 43-2		
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,487	
				2,487
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2		
	SOCIAL WORKER	XVIII B 45-2	884	
				884
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number OTTAWA PAVILION LTD **#0039230** **Report Period Beginning: 01/01/2018** **Ending: 12/31/2018**

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION			
				0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B		0
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	105,537	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	69,327	
				174,864
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	53,681	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	21,815	
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F	9,292	
	LICENSES & PERMITS	XIX F	10,230	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F		
	ADVERTISING-YELLOW PAGES	VI 28 XIX F		
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	14,411	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	1,032	
	PATIENT BACKGROUND CHECKS	XIX F	3,560	
				114,021
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		25,665	
	EQUIPMENT REPAIR & MAINTENANCE		29,126	
	OUTSIDE CLERICAL SERVICES		750,596	
	PENALTIES / OVERDRAFT CHARGES	VI 18	8,745	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS			
	TELEPHONE		22,817	
	MESSENGER SERVICE			
				836,949

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	429,402	
	UNEMPLOYMENT COMPENSATION	XIX D	57,075	
	WORKERS COMPENSATION INSURANC	XIX D	127,823	
	HOSPITALIZATION INSURANCE	XIX D	129,235	
	EMPLOYEE BENEFITS - OTHER	XIX D	17,978	
	EMPLOYEE PHYSICAL EXAMS	XIX D		
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D		
	PENSION/PROFIT SHARING PLANS	XIX D		
				761,513
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,867	
				4,867
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	10,777	
				10,777
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF			
				0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		214,682	
				214,682
27	**OTHER**			
	BAD DEBTS	VI 24	67,391	
				67,391

GRAND TOTAL COLUMN 3 OTHER **2,484,763**

OTTAWA PAVILION LTD
SCHEDULES
12/31/2018

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

TOTAL FOOD PURCHASE	296,928
LESS SALES TAX	(3,558)
NET FOOD	293,370
TOTAL PATIENT CENSUS	44,077
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	132,231
ADD # EMPLOYEE MEALS/DAY	10
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	3,650
PATIENT MEALS	132,231
ADD EMPLOYEE MEALS	3,650
TOTAL MEALS/YEAR	135,881
NET FOOD	293,370
DIVIDE TOTAL MEALS/YEAR	135,881
COST PER MEAL	2.16
TIMES EMPLOYEE MEALS	3,650
EMPLOYEE MEAL RECLASSIFIC	**7,884**

Facility Name & ID Number OTTAWA PAVILION LTD #0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			31,752	31,752		31,752	428,411	460,163			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			124,402	124,402		124,402	594,180	718,582			32
33	Real Estate Taxes							177,087	177,087			33
34	Rent-Facility & Grounds			1,500,000	1,500,000		1,500,000	(1,500,000)				34
35	Rent-Equipment & Vehicles			60,876	60,876		60,876	14,308	75,184			35
36	Other (specify):* STORAGE							83,664	83,664			36
37	**TOTAL Ownership**			1,717,030	1,717,030		1,717,030	(202,350)	1,514,680			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		218,861		218,861		218,861		218,861			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			288,063	288,063		288,063		288,063			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		218,861	288,063	506,924		506,924		506,924			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,697,961	856,287	4,489,856	11,044,104		11,044,104	(592,247)	10,451,857			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(26,776)	30		9
10	Interest and Other Investment Income	(53,810)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,558)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,745)	21		18
19	Entertainment				19
20	Contributions	(14,411)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(67,391)	27		24
25	Fund Raising, Advertising and Promotional	(53,681)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (228,372)		$	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)	(363,875)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (363,875)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (592,247)		37

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

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

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

OTTAWA PAVILION LTD

ID# 0039230

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	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 LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,558)	0	0	0	0	0	0	0	0	0	0	(3,558)	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	1,536	0	0	0	0	0	0	0	0	1,536	5
6	Maintenance	0	0	8,593	10,879	0	0	0	0	0	0	0	19,472	6
7	Other (specify):*	0	0	1,045	0	0	0	0	0	0	0	0	1,045	7
8	**TOTAL General Services**	(3,558)	0	11,174	10,879	0	0	0	0	0	0	0	18,495	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	230,476	0	0	0	0	0	0	0	230,476	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,067	4,764	0	0	0	0	0	0	0	0	17,831	19
20	Fees, Subscriptions & Promotions	(68,092)	0	2,886	0	0	0	0	0	0	0	0	(65,206)	20
21	Clerical & General Office Expenses	(8,745)	(750,596)	112,976	11,846	0	0	0	0	0	0	0	(634,519)	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	715	0	0	0	0	0	0	0	0	715	24
25	Other Admin. Staff Transportation	0	0	7,479	0	0	0	0	0	0	0	0	7,479	25
26	Insurance-Prop.Liab.Malpractice	0	11,762	6,596	0	0	0	0	0	0	0	0	18,358	26
27	Other (specify):*	(67,391)	0	83,865	0	0	0	0	0	0	0	0	16,474	27
28	**TOTAL General Administration**	(144,228)	(725,767)	219,281	242,322	0	0	0	0	0	0	0	(408,392)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(147,786)	(725,767)	230,455	253,201	0	0	0	0	0	0	0	(389,897)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(26,776)	451,995	3,192	0	0	0	0	0	0	0	0	428,411	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(53,810)	645,134	2,856	0	0	0	0	0	0	0	0	594,180	32
33	Real Estate Taxes	0	170,933	6,154	0	0	0	0	0	0	0	0	177,087	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	14,308	0	0	0	0	0	0	0	0	14,308	35
36	Other (specify):*	0	83,664	0	0	0	0	0	0	0	0	0	83,664	36
37	TOTAL Ownership	(80,586)	(148,274)	26,510	0	0	0	0	0	0	0	0	(202,350)	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)	(228,372)	(874,041)	256,965	253,201	0	0	0	0	0	0	0	(592,247)	45

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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				

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	21	BOOKKEEPING SERVICES	$ 750,596	DYNAMIC HEALTH CARE CONSULTANTS		$	$ (750,596)	1
2	V								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				451,995	451,995	8
9	V	32	INTEREST				645,134	645,134	9
10	V	33	REAL ESTATE TAXES				170,933	170,933	10
11	V	19	LEGAL & ACCOUNTING				13,067	13,067	11
12	V	26	INSURANCE				11,762	11,762	12
13	V	36	INSURANCE-MIP				83,664	83,664	13
14	Total			$ 2,250,596			$ 1,376,555	$ * (874,041)	14

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

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	$ 1,536	$ 1,536	15
16	V	6	REPAIR & MAINT. - SALARIES				1,827	1,827	16
17	V	6	REPAIR & MAINT.-OTHER EXPENSE				6,766	6,766	17
18	V	7	EMP BEN-GEN SERV				1,045	1,045	18
19	V	19	PROFESSIONAL FEES				4,764	4,764	19
20	V	20	DUES AND SUBSCRIPTION				2,886	2,886	20
21	V	21	CLERICAL & GENERAL - SALARIES				83,659	83,659	21
22	V	21	CLERICAL & GENERAL-OTHER EXPENSE				29,317	29,317	22
23	V	24	SEMINARS AND TRAVEL				715	715	23
24	V	25	AUTO EXPENSE				7,479	7,479	24
25	V	26	INSURANCE				6,596	6,596	25
26	V	27	EMP. BEN. - GEN, ADMIN.				83,865	83,865	26
27	V	30	DEPRECIATION				3,192	3,192	27
28	V	32	INTEREST				2,856	2,856	28
29	V	33	REAL ESTATE TAXES				6,154	6,154	29
30	V	35	AUTO RENTAL				13,452	13,452	30
31	V	35	EQUIPMENT RENTAL				856	856	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 256,965	$ * 256,965	39

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

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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%	$ 10,879	$ 10,879	15
16	V	17	ADMIN COMP - M MAUER				29,150	29,150	16
17	V	17	ADMIN COMP - M AARON				36,500	36,500	17
18	V	17	ADMIN COMP - D AARON				3,470	3,470	18
19	V	17	ADMIN COMP - S GOLDSTEIN				59,971	59,971	19
20	V	17	ADMIN COMP - D KUFTA				28,565	28,565	20
21	V	17	ADMIN COMP -V DAVIS NON OWNER				19,416	19,416	21
22	V	17	ADMIN COMP - VAR NON OWNER				6,668	6,668	22
23	V	17	ADMIN COMP - CFO NON OWNER				31,748	31,748	23
24	V	17	ADMIN COMP-CONTROLLER NON OWNER				14,988	14,988	24
25	V	21	CLERICAL COMP - S AARON				11,846	11,846	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 253,201	$ * 253,201	39

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

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	ADMINISTRATIV	26.04		7.3	14.60	SALARY	$ 36,500	17-7	1
2	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIV	14.70	SCHEDULE	5.83	14.58	SALARY	29,150	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL	0.53	ATTACHED	5.83	15.76	SALARY	11,846	21-7	3
4	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE	0.53		7.16	17.90	SALARY	10,879	6-7	4
5	DIANA KUFTA	SHAREHOLDER	ADMINISTRATIV	0.53		7.3	18.25	SALARY	28,565	17-7	5
6	STEVEN GOLDSTEIN	SHAREHOLDER	ADMINISTRATIVE			15		SALARY	59,971	17-7	6
7	DANIEL AARON	SHAREHOLDER	ADMINISTRATIVE			1.36	2.72	SALARY	3,470	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 180,381		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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	302,492	10	$ 10,544	$	44,077	$ 1,536	1
2	6	REPAIR & MAINT. - SALARIES	PATIENT DAYS	302,492	10	12,541	12,541	44,077	1,827	2
3	6	REPAIR & MAINT.-OTHER EXPE	PATIENT DAYS	302,492	10	46,430		44,077	6,766	3
4	7	EMP BEN-GEN SERV	PATIENT DAYS	302,492	10	7,174		44,077	1,045	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	302,492	10	32,693		44,077	4,764	5
6	20	DUES AND SUBSCRIPTION	PATIENT DAYS	302,492	10	19,807		44,077	2,886	6
7	21	CLERICAL & GENERAL - SALARI	PATIENT DAYS	302,492	10	574,139	574,139	44,077	83,659	7
8	21	CLERICAL & GENERAL-OTHER I	PATIENT DAYS	302,492	10	201,196		44,077	29,317	8
9	24	SEMINARS AND TRAVEL	PATIENT DAYS	302,492	10	4,903		44,077	715	9
10	25	AUTO EXPENSE	PATIENT DAYS	302,492	10	51,327		44,077	7,479	10
11	26	INSURANCE	PATIENT DAYS	302,492	10	45,267		44,077	6,596	11
12	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	302,492	10	575,549		44,077	83,865	12
13	30	DEPRECIATION	PATIENT DAYS	302,492	10	21,903		44,077	3,192	13
14	32	INTEREST	PATIENT DAYS	302,492	10	19,599		44,077	2,856	14
15	33	REAL ESTATE TAXES	PATIENT DAYS	302,492	10	42,234		44,077	6,154	15
16	35	AUTO RENTAL	PATIENT DAYS	302,492	10	92,319		44,077	13,452	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	302,492	10	5,875		44,077	856	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,763,500	$ 586,680		$ 256,965	25

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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	$ 60,778	$	7	$ 10,879	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	10	200,000		6	29,150	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	7	200,000		7	36,500	3
4	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	30	10	76,541		1	3,470	4
5	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	159,922		15	59,971	5
6	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	7	156,522		7	28,565	6
7	17	ADMIN COMP -V DAVIS NON OW	WGHTD AVG HOURS	40	9	132,083		6	19,416	7
8	17	ADMIN COMP - VAR NON OWNEI	WGHTD AVG HOURS	40	7	36,458		8	6,668	8
9	17	ADMIN COMP - CFO NON OWNEI	WGHTD AVG HOURS	40	9	215,972		6	31,748	9
10	17	ADMIN COMP-CONTROLLER NO	WGHTD AVG HOURS	40	9	101,958		6	14,988	10
11	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	80,583		6	11,846	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,420,817	$		$ 253,201	25

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 15,177,138	10/1/2052	5.4500	$ 645,134	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL	X		WORKING CAPITAL				754,633			63,760	6
7	RELATED PARTY	X		WORKING CAPITAL							60,642	7
8	MGMT ALLOCATION										2,856	8
9	TOTAL Facility Related				$82,849.05		$ 16,102,900	$ 15,931,771			$ 772,392	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	$ 15,931,771			$ 772,392	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 83,664 Line # 36

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

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

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	179,500	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.)	$	175,216	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,284)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	175,217	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.	$	170,933	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	124,901	8
	2014	165,335	9
	2015	175,323	10
	2016	179,730	11
	2017	175,217	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OTTAWA PAVILION LTD COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0039230

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-13-111-001	NURSING HOME	$ 175,216.52	$ 175,216.52
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 175,216.52	$ 175,216.52

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 [ ] (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).

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 LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 364,629	4
5	118				15,864,469		39	412,070	412,070	2,567,820	5
6											6
7	RELATED PARTY				63,873		35	1,825	1,825	37,201	7
8											8
	Improvement Type**										
9	ROOF			2005	30,875		39	791	791	13,796	9
10	POSIFLEX PERSONA URU SCANNER			2011	18,819		39	482	482	4,299	10
11	SIGN			2012	4,243		15	283	283	1,840	11
12	ELECTRICAL, PUMP			2012	2,823		39	72	72	547	12
13	SPRINKLER/FIRE ALARM WORK			2012	4,881		39	125	125	934	13
14	CORNER GUARDS, LIGHTING, CURTAINS			2012	6,915		39	178	178	1,327	14
15	MIXING VALVE& FAN MOTORS			2013	9,973		39	256	256	1,356	15
16	CORNER GUARDS			2013	1,837		39	47	47	248	16
17	PLUMBING WORK & SINKS			2013	3,352		39	85	85	452	17
18	ANTENNAS FOR PHONES			2013	1,675		39	43	43	226	18
19	SMOKE DETECTOR			2013	1,005		39	26	26	140	19
20	HEAT PUMP, AC REPAIR, BOOSTER PUMP			2015	14,715		39	366	366	1,287	20
21	WALK IN COOLER REPAIR			2015	4,083		39	106	106	370	21
22	SIGNAGE			2015	2,479		39	63	63	221	22
23	LED HDTV, JUMBO BUTTON REMOTE CONTROLS			2015	1,047		39	28	28	97	23
24	DISPOSER			2015	2,574		39	71	71	246	24
25	PARKING LOT SEAL & STRIPE			2015	2,617		39	71	71	247	25
26	HEAT PUMP			2016	982		39	25	25	75	26
27	DOOR CLOSERS			2016	1,294		39	28	28	84	27
28	AIR DUCT & FIRE DAMPERS			2016	5,986		39	66	66	198	28
29	PARKING LOT SEAL & STRIPE			2016	2,342		39	39	39	117	29
30	RIVER ROCK			2016	1,193		39	20	20	60	30
31	NURSE CALL LIGHT			2016	2,732		39	12	12	36	31
32	SPRINKLER SYSTEM REPAIR			2017	8,227		39	105	105	315	32
33	AC CONDENSOR			2017	7,400		39	95	95	285	33
34	ELECTRICAL OUTLETS/CALL LIGHT BOX			2017	7,400		39	95	95	285	34
35	DOOR CLOSERS			2017	1,768		39	23	23	69	35
36	ROOF REPAIR			2017	3,800		39	49	49	147	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	ELECTRICAL RED OUTLETS	2018	$ 800	$	39	$ 20	$ 20	$ 20	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	BOOK DEPRECIATION			485,272			(485,272)		64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 16,636,179	$ 485,272		$ 431,671	$ (53,601)	$ 2,998,974	70

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

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 236,256	$	$ 23,626	$ 23,626	10	$ 106,341	71
72	Current Year Purchases	10,451		522	522	10	522	72
73	Fully Depreciated Assets							73
74	RELATED PARTY			884	884			74
75	TOTALS	$ 246,707	$	$ 25,032	$ 25,032		$ 106,863	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	ADMINISTRATIVE	ATS CADILLAC 2017	2018	$ 31,577	$ 1,667	$ 1,667	$	7	$ 1,667	76
77										77
78	RELATED PARTY					1,793	1,793			78
79										79
80	TOTALS			$ 31,577	$ 1,667	$ 3,460	$ 1,793		$ 1,667	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)	$ 18,721,402	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 486,939	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 460,163	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (26,776)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,107,504	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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.		$
13.		$
14.		$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 50,146 Description: SEE ATTACHED SCHEDULE
(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	FORD STARCRAFT	$ 704.00	$ 8,448	17
18	ADMINISTRATIVE	2018 BUIC ENCORE	228.24	2,282	18
19					19
20					20
21	TOTAL		$ 932.24	$ 10,730	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							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				194,747		194,747	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): RENTALS	39-2					24,114		24,114	13
14	TOTAL			$		$	$ 218,861		$ 218,861	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 LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 437,236	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 276,104)	1,805,105		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	149,451		6
7	Other Prepaid Expenses	13,269		7
8	Accounts Receivable (owners or related parties)	1,412,235		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,817,296	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	159,391		15
16	Equipment, at Historical Cost	291,844		16
17	Accumulated Depreciation (book methods)	(227,258)		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	31,010		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 254,987	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,072,283	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 682,732	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	828,335		29
30	Accrued Salaries Payable	471,369		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,945		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,183		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)**	$ 2,008,564	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,008,564	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,063,719	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,072,283	$	48

***(See instructions.)**

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,987,638	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(1,679)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,985,959	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	338,196	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	(175,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES	(85,436)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 77,760	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)**	$ 2,063,719	24 *

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

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 11,146,175	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,146,175	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	167,141	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 167,141	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	3,465	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	292	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	11,417	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15,174	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	53,810	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 53,810	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,382,300	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,387,494	31
32	Health Care	4,926,197	32
33	General Administration	2,506,459	33
	B. Capital Expense		
34	Ownership	1,717,030	34
	C. Ancillary Expense		
35	Special Cost Centers	218,861	35
36	Provider Participation Fee	288,063	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,044,104	40
41	**Income before Income Taxes (line 30 minus line 40)****	338,196	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 338,196	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,206,938	44
45	Private Pay - Net Inpatient Revenue	3,503,988	45
46	Medicare - Net Inpatient Revenue	4,435,249	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,146,175	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 LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	2,120	1,944	$ 99,587	$ 51.23	1
2	Assistant Director of Nursing	2,080	1,888	75,361	39.92	2
3	Registered Nurses	20,785	19,641	579,069	29.48	3
4	Licensed Practical Nurses	28,772	27,124	813,092	29.98	4
5	CNAs & Orderlies	136,146	130,490	1,996,187	15.30	5
6	CNA Trainees					6
7	Licensed Therapist	21,095	19,359	785,423	40.57	7
8	Rehab/Therapy Aides	1,080	1,004	15,541	15.48	8
9	Activity Director	2,169	1,985	37,906	19.10	9
10	Activity Assistants	12,087	11,271	119,123	10.57	10
11	Social Service Workers	2,802	2,448	49,266	20.13	11
12	Dietician					12
13	Food Service Supervisor	2,079	1,790	38,976	21.77	13
14	Head Cook	2,573	2,495	28,886	11.58	14
15	Cook Helpers/Assistants	19,465	18,393	224,036	12.18	15
16	Dishwashers					16
17	Maintenance Workers	4,756	4,370	79,637	18.22	17
18	Housekeepers	24,647	22,802	266,573	11.69	18
19	Laundry	4,576	4,194	59,134	14.10	19
20	Administrator	2,347	2,024	107,272	53.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,502	1,374	36,395	26.49	23
24	Clerical	7,685	7,060	94,982	13.45	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	1,705	1,537	19,717	12.83	31
32	Other Health C: Care Plan Coord	3,802	3,190	119,388	37.43	32
33	Other(specify) ADMITTING	2,080	1,920	52,410	27.30	33
34	TOTAL (lines 1 - 33)	306,353	288,303	$ 5,697,961 *	$ 19.76	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	$ 9,793	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	6,759	10-3	38
39	Pharmacist Consultant	H	16,602	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	2,487	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 41,641		49

C. CONTRACT NURSES

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

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ALEX BEJAR	ADMINISTRATOR	0	$ 107,272
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 107,272

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 SCHEDULE		174,864
SEE LEGAL SCHEDULE ATTACHED		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 174,864

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 127,823
Unemployment Compensation Insurance	57,075
FICA Taxes	429,402
Employee Health Insurance	129,235
Employee Meals	7,884
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	17,978
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 769,397

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	21,815
Health Care Worker Background Check	1,032
(Indicate # of checks performed)	
Patient Background Checks	3,560
TRUST/FRANCHISE/CONTRIB/ETC	14,411
MARKETING/ADV/PROMO	53,681
LICENSES/DUES/SUBSCRIPTIONS	17,532
MGMT CO ALLOC	2,886
TRUST/FRANCHISE/CONTRIB/ETC	(14,411)
Less: Public Relations Expense	(0)
Non-allowable advertising	(53,681)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,815

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,777
MGMT CO ALLOC	715
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,492

* Attach copy of IMRF notifications

**See instructions.

OTTAWA PAVILION LTD
LEGAL FEE SCHEDULE
12/31/2018

DATE	NAME	DESCRIPTION	AMOUNT
			205.00
11/30/2018	BANK FINANCIAL	LOAN COUNSEL	
			78.00
3/1/2018	MUCH SHELIST	GENERAL COUNSELING	507.00
4/1/2018	MUCH SHELIST	GENERAL COUNSELING	2,657.00
5/1/2018	MUCH SHELIST	GENERAL COUNSELING	2,352.47
6/1/2018	MUCH SHELIST	GENERAL COUNSELING	234.00
7/1/2018	MUCH SHELIST	GENERAL COUNSELING	156.00
8/1/2018	MUCH SHELIST	GENERAL COUNSELING	195.00
9/1/2018	MUCH SHELIST	GENERAL COUNSELING	273.00
10/1/2018	MUCH SHELIST	GENERAL COUNSELING	350.00
10/1/2018	MUCH SHELIST	GENERAL COUNSELING	26.13
11/1/2018	MUCH SHELIST	FED EX & MESSENGER	457.00
11/30/2018	MUCH SHELIST	GENERAL COUNSELING	2,068.33
12/31/2018	MUCH SHELIST	GENERAL COUNSELING	
			22.50
2/28/2018	STONE POGRUND & KOREY	GENERAL LITIGATION & COLLECTIONS	183.56
3/31/2018	STONE POGRUND & KOREY	GENERAL LITIGATION & COLLECTIONS	555.34
4/30/2018	STONE POGRUND & KOREY	GENERAL LITIGATION & COLLECTIONS	382.50
5/31/2018	STONE POGRUND & KOREY	GENERAL LITIGATION & COLLECTIONS	532.33
6/30/2018	STONE POGRUND & KOREY	GENERAL LITIGATION & COLLECTIONS	239.33
7/31/2018	STONE POGRUND & KOREY	GENERAL LITIGATION & COLLECTIONS	1,363.34
8/31/2018	STONE POGRUND & KOREY	GENERAL LITIGATION & COLLECTIONS	227.83
9/30/2018	STONE POGRUND & KOREY	GENERAL LITIGATION & COLLECTIONS	958.25
11/1/2018	STONE POGRUND & KOREY	GENERAL LITIGATION & COLLECTIONS	403.24
11/30/2018	STONE POGRUND & KOREY	GENERAL LITIGATION & COLLECTIONS	343.05
12/31/2018	STONE POGRUND & KOREY	GENERAL LITIGATION & COLLECTIONS	
			4,885.00
3/5/2018	WILLIAM C HEEKIN	LABOR & EMPLOYMENT	
			1,617.95
2/22/2018	VON BRIESEN & ROPER	LABOR & EMPLOYMENT	1,072.00
3/21/2018	VON BRIESEN & ROPER	LABOR & EMPLOYMENT	2,311.50
3/30/2018	VON BRIESEN & ROPER	EMPLOYEE ARBITRATION	2,546.00
5/16/2018	VON BRIESEN & ROPER	EMPLOYEE ARBITRATION	335.00
6/19/2018	VON BRIESEN & ROPER	EMPLOYEE ARBITRATION	
	TOTAL		**27,537.65**

Facility Name & ID Number OTTAWA PAVILION LTD # 0039230 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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?
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? **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. $ **32,898** 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. $ **288,063**
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. $ **7,884** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

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

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

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

(19) 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