		FOR BHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 12/010/1993

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 1/1/2020 to 12/31/2020 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, 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
(Telephone) (847) 675-3585 Fax # (847) 675-3585

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: 1/1/2020 Ending: 12/31/2020

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	49,410	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	49,410	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			8,259	8,259	8
9	SNF/PED					9
10	ICF	22,037	14,575		36,612	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,037	14,575	8,259	44,871	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.81%

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 8,259

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	289,921	26,511	19,288	335,720		335,720		335,720			1
2	Food Purchase		326,342		326,342	(8,491)	317,851	(5,624)	312,227			2
3	Housekeeping	315,181	49,006		364,187		364,187		364,187			3
4	Laundry	17,924	13,111	1,408	32,443		32,443		32,443			4
5	Heat and Other Utilities			344,940	344,940		344,940	1,623	346,563			5
6	Maintenance	120,243	66,367	22,371	208,981		208,981	20,731	229,712			6
7	Other (specify):*			19,747	19,747		19,747		19,747			7
8	**TOTAL General Services**	743,269	481,337	407,754	1,632,360	(8,491)	1,623,869	16,730	1,640,599			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	3,771,451	312,979	331,962	4,416,392		4,416,392	17,594	4,433,986			10
10a	Therapy	755,296			755,296		755,296		755,296			10a
11	Activities	143,781	9,862	1,614	155,257		155,257		155,257			11
12	Social Services	60,254	1,708	476	62,438		62,438		62,438			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,730,782	324,549	340,052	5,395,383		5,395,383	17,594	5,412,977			16
	C. General Administration											
17	Administrative	128,314			128,314		128,314	245,500	373,814			17
18	Directors Fees											18
19	Professional Services			178,274	178,274		178,274	16,036	194,310			19
20	Dues, Fees, Subscriptions & Promotions			151,819	151,819		151,819	(90,275)	61,544			20
21	Clerical & General Office Expenses	168,158	38,546	556,280	762,984		762,984	(326,778)	436,206			21
22	Employee Benefits & Payroll Taxes			880,895	880,895	8,491	889,386		889,386			22
23	Inservice Training & Education			351	351		351		351			23
24	Travel and Seminar			9,561	9,561		9,561	382	9,943			24
25	Other Admin. Staff Transportation							3,796	3,796			25
26	Insurance-Prop.Liab.Malpractice			483,221	483,221		483,221	21,059	504,280			26
27	Other (specify):*	64,586		201,704	266,290		266,290	(111,437)	154,853			27
28	**TOTAL General Administration**	361,058	38,546	2,462,105	2,861,709	8,491	2,870,200	(241,717)	2,628,483			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,835,109	844,432	3,209,911	9,889,452		9,889,452	(207,393)	9,682,059			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: 1/1/2020** **Ending: 12/31/2020**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	19,288	
	REPAIRS & MAINTENANCE		0	
	CONTRACTED DIETARY SERVICES		0	
				19,288
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,408	
	CONTRACTED LAUNDRY SERVICES		0	
				1,408
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		13,479	
	ELECTRICITY		270,033	
	WATER		46,402	
	CABLE TV - LOBBY		15,026	
				344,940
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		450	
	PAINTING & DECORATING		433	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,833	
	ELEVATOR MAINTENANCE & REPAIR		7,158	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,497	
	FIRE SERVICE		0	
				22,371
7	**OTHER**			
	SCAVENGER		19,747	
	SECURITY SERVICE		0	
				19,747
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES		6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	238,846	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	84,048	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	9,068	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2		
				331,962
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 CONSULTAN	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	1,614	
				1,614
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	476	
				476
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID# OTTAWA PAVILION **#0039230 Report Period Beginning: 1/1/2020** **Ending: 12/31/2020**

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	98,638	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	79,636	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		0	
				178,274
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	77,567	
	EMPLOYEE WANT ADS	XIX F	23,180	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	12,363	
	LICENSES & PERMITS	XIX F	15,362	
	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	15,626	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	644	
	PATIENT BACKGROUND CHECKS	XIX F	7,077	
				151,819
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,927	
	EQUIPMENT REPAIR & MAINTENANCE		24,470	
	OUTSIDE CLERICAL SERVICES		505,693	
	PENALTIES / OVERDRAFT CHARGES	VI 18	39	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		19,151	
	MESSENGER SERVICE		0	
				556,280

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	434,142	
	UNEMPLOYMENT COMPENSATION	XIX D	28,394	
	WORKERS COMPENSATION INSURANCE	XIX D	163,675	
	HOSPITALIZATION INSURANCE	XIX D	212,188	
	EMPLOYEE BENEFITS - OTHER	XIX D	42,496	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				880,895
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		351	
				351
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	9,561	
				9,561
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		0	
				0
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		483,221	
				483,221
27	**OTHER**			
	BAD DEBTS	VI 24	201,704	
				201,704

GRAND TOTAL COLUMN 3 OTHER **3,209,911**

OTTAWA PAVILION
SCHEDULES
12/31/2020

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

TOTAL FOOD PURCHASE	326,342
LESS SALES TAX	(5,624)
NET FOOD	320,718
TOTAL PATIENT CENSUS	44,871
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	134,613
ADD # EMPLOYEE MEALS/DAY	10
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	3,660
PATIENT MEALS	134,613
ADD EMPLOYEE MEALS	3,660
TOTAL MEALS/YEAR	138,273
NET FOOD	320,718
DIVIDE TOTAL MEALS/YEAR	138,273
COST PER MEAL	2
TIMES EMPLOYEE MEALS	3,660
EMPLOYEE MEAL RECLASSIFICATION	**8,491**

Facility Name & ID Number OTTAWA PAVILION #0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			17,054	17,054		17,054	441,602	458,656			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,737	70,737		70,737	633,735	704,472			32
33	Real Estate Taxes							182,568	182,568			33
34	Rent-Facility & Grounds			1,500,000	1,500,000		1,500,000	(1,500,000)				34
35	Rent-Equipment & Vehicles			65,664	65,664		65,664	14,593	80,257			35
36	Other (specify):*							84,998	84,998			36
37	**TOTAL Ownership**			1,653,455	1,653,455		1,653,455	(142,504)	1,510,951			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		207,819		207,819		207,819		207,819			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			288,910	288,910		288,910		288,910			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		207,819	288,910	496,729		496,729		496,729			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,835,109	1,052,251	5,152,276	12,039,636		12,039,636	(349,897)	11,689,739			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: 1/1/2020 Ending: 12/31/2020

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 Reference	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	21,946	30		9
10	Interest and Other Investment Income	(42,385)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,624)	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	(39)	21		18
19	Entertainment		20		19
20	Contributions	(15,626)	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	(201,704)	27		24
25	Fund Raising, Advertising and Promotional	(77,567)	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 PAGE 5A		22		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (320,999)		$	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)	(28,898)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (28,898)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (349,897)		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

ID# 0039230

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	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: 1/1/2020 Ending: 12/31/2020

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	(5,624)	0	0	0	0	0	0	0	0	0	0	(5,624)	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	1,623	0	0	0	0	0	0	0	0	1,623	5
6	Maintenance	0	0	10,091	10,640	0	0	0	0	0	0	0	20,731	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,624)	0	11,714	10,640	0	0	0	0	0	0	0	16,730	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	17,594	0	0	0	0	0	0	0	0	17,594	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	17,594	0	0	0	0	0	0	0	0	17,594	16
	C. General Administration													
17	Administrative	0	0	0	245,500	0	0	0	0	0	0	0	245,500	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,250	4,786	0	0	0	0	0	0	0	0	16,036	19
20	Fees, Subscriptions & Promotions	(93,193)	0	2,918	0	0	0	0	0	0	0	0	(90,275)	20
21	Clerical & General Office Expenses	(39)	0	(349,061)	22,322	0	0	0	0	0	0	0	(326,778)	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	382	0	0	0	0	0	0	0	0	382	24
25	Other Admin. Staff Transportation	0	0	3,796	0	0	0	0	0	0	0	0	3,796	25
26	Insurance-Prop.Liab.Malpractice	0	16,317	4,742	0	0	0	0	0	0	0	0	21,059	26
27	Other (specify):*	(201,704)	0	90,267	0	0	0	0	0	0	0	0	(111,437)	27
28	**TOTAL General Administration**	(294,936)	27,567	(242,170)	267,822	0	0	0	0	0	0	0	(241,717)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(300,560)	27,567	(212,862)	278,462	0	0	0	0	0	0	0	(207,393)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OTTAWA PAVILION # 0039230 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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	21,946	417,932	1,724	0	0	0	0	0	0	0	0	441,602	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(42,385)	672,925	3,195	0	0	0	0	0	0	0	0	633,735	32
33	Real Estate Taxes	0	176,563	6,005	0	0	0	0	0	0	0	0	182,568	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	14,593	0	0	0	0	0	0	0	0	14,593	35
36	Other (specify):*	0	84,998	0	0	0	0	0	0	0	0	0	84,998	36
37	**TOTAL Ownership**	(20,439)	(147,582)	25,517	0	0	0	0	0	0	0	0	(142,504)	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)**	(320,999)	(120,015)	(187,345)	278,462	0	0	0	0	0	0	0	(349,897)	45

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	34	RENT	$ 1,500,000	800 E. CENTER ST		$	$ (1,500,000)	1
2	V	30	DEPRECIATION				417,932	417,932	2
3	V	32	INTEREST				669,577	669,577	3
4	V	32	AMORT LOAN COST				3,348	3,348	4
5	V	33	REAL ESTATE TAXES				176,563	176,563	5
6	V	19	LEGAL & ACCOUNTING				11,250	11,250	6
7	V	26	INSURANCE				16,317	16,317	7
8	V	36	INSURANCE-MIP				84,998	84,998	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,500,000			$ 1,379,985	$ * (120,015)	14

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	21	BOOKKEEPING SERVICES	$ 505,693	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	$	$ (505,693)	15
16	V								16
17	V								17
18	V								18
19	V	5	UTILITIES				1,623	1,623	19
20	V	6	REPAIR & MAINT.-OTHER EXPENSE				10,091	10,091	20
21	V	10	NURSE CONSULTANT				17,594	17,594	21
22	V	19	PROFESSIONAL FEES				4,786	4,786	22
23	V	20	DUES AND SUBSCRIPTION				2,918	2,918	23
24	V	21	CLERICAL & GENERAL - SALARIES				119,965	119,965	24
25	V	21	CLERICAL & GENERAL-OTHER EXPENSE				36,667	36,667	25
26	V	24	SEMINARS AND TRAVEL				382	382	26
27	V	25	AUTO EXPENSE				3,796	3,796	27
28	V	26	INSURANCE				4,742	4,742	28
29	V	27	EMP. BEN. - GEN, ADMIN.				90,267	90,267	29
30	V	30	DEPRECIATION				1,724	1,724	30
31	V	32	INTEREST				3,195	3,195	31
32	V	33	REAL ESTATE TAXES				6,005	6,005	32
33	V	35	AUTO RENTAL				14,198	14,198	33
34	V	35	EQUIPMENT RENTAL				395	395	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 505,693			$ 318,348	$ * (187,345)	39

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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%	$ 10,640	$ 10,640	15
16	V	17	ADMIN COMP - M MAUER				36,875	36,875	16
17	V	17	ADMIN COMP - M AARON				46,250	46,250	17
18	V	17	ADMIN COMP - F AARON						18
19	V	17	ADMIN COMP - D AARON				3,231	3,231	19
20	V	17	ADMIN COMP - S GOLDSTEIN				86,250	86,250	20
21	V	17	ADMIN COMP - R AARON						21
22	V	17	ADMIN COMP - S HARAMARAS						22
23	V	17	ADMIN COMP - D KUFTA				31,084	31,084	23
24	V	17	ADMIN COMP - HOWARD ALTER						24
25	V	17	ADMIN COMP - NON OWNER - V DAVIS				24,687	24,687	25
26	V	17	ADMIN COMP - CONTROLLER-NON OWNER				17,123	17,123	26
27	V	21	CLERICAL COMP - S AARON				14,285	14,285	27
28	V	21	CLERICAL COMP - E MARYLES				8,037	8,037	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			$			$ 278,462	$ * 278,462	39

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			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	WATERFRONT TERRACE INC	CHICAGO				6
7	SUSAN KOPLIN HARAMARAS	.53	WILLOW CREST	SANDWICH				7
8	DENNIS NEHMER	.53	WOODBRIDGE NURSING PAVILION LTD	CHICAGO				8
9	SHARON AARON	.53						9
10	DIANA KUFTA	.53						10
11	SYLVIA AARON	.21	WOODRIDGE SUPPORTING LIVING RESID	GALESBURG				11
12	CHANA MAUER-RAY	5.67	WOODRIDGE SUPPORTING LIVING RESIDENCE OF GENESEO					12
13	ESTHER MAUER MARYLES	5.67		GENESEO				13
14	FRANCES MAUER	7.56						14
15	ABRAHAM STERN	15.54						15
16	DEVORA GOLDSTEIN	7.56						16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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		7.4	14.80	SALARY	$ 46,250	17-7	1
2	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIV	14.70	SCHEDULE	5.9	14.75	SALARY	36,875	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL	0.53	ATTACHED	5.96	14.90	SALARY	14,285	21-1	3
4	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE	0.53		7.26	18.15	SALARY	10,640	6-1	4
5	DIANA KUFTA	SHAREHOLDER	ADMINISTRATIV	0.53		7.4	18.50	SALARY	31,084	17-7	5
6	STEVEN GOLDSTEIN	RELATIVE	ADMINISTRATIVE			15		SALARY	86,250	17-7	6
7	DANIEL AARON	RELATIVE	ADMINISTRATIVE			0.75	1.36	SALARY	3,231	17-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL	5.67		4.46	11.15	SALARY	8,037	21-1	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 236,652		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: 1/1/2020 Ending: 2/31/2020

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	296,074	9	$ 10,707	$	44,871	$ 1,623	1
2	6	REPAIR & MAINT.-OTHER EXPEI	PATIENT DAYS	296,074	9	66,584		44,871	10,091	2
3	10	NURSE CONSULTANT	PATIENT DAYS	296,074	9	116,092		44,871	17,594	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	296,074	9	31,579		44,871	4,786	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	296,074	9	19,254		44,871	2,918	5
6	21	CLERICAL & GENERAL - SALARI	PATIENT DAYS	296,074	9	791,573	791,573	44,871	119,965	6
7	21	CLERICAL & GENERAL-OTHER I	PATIENT DAYS	296,074	9	241,939		44,871	36,667	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	296,074	9	2,520		44,871	382	8
9	25	AUTO EXPENSE	PATIENT DAYS	296,074	9	25,044		44,871	3,796	9
10	26	INSURANCE	PATIENT DAYS	296,074	9	31,289		44,871	4,742	10
11	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	296,074	9	595,611		44,871	90,267	11
12	30	DEPRECIATION	PATIENT DAYS	296,074	9	11,374		44,871	1,724	12
13	32	INTEREST	PATIENT DAYS	296,074	9	21,081		44,871	3,195	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	296,074	9	39,621		44,871	6,005	14
15	35	AUTO RENTAL	PATIENT DAYS	296,074	9	93,680		44,871	14,198	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	296,074	9	2,605		44,871	395	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,100,553	$ 791,573		$ 318,348	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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	5	$ 58,624	$ 58,624	7	$ 10,640	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	9	250,000	250,000	6	36,875	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	5	250,000	250,000	7	46,250	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	3	127,500	127,500			4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	5	9	21,541	21,541	1	3,231	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	230,000	230,000	15	86,250	6
7	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	6	3	21,541	21,541			7
8	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	1	69,011	69,011			8
9	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	5	168,022	168,022	7	31,084	9
10	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			10
11	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	5	132,015	132,015	7	24,687	11
12	17	ADMIN COMP - CONTROLLER-N	WGHTD AVG HOURS	40	9	114,916	114,916	6	17,123	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	95,871	95,871	6	14,285	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	40	9	72,080	72,080	4	8,037	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,623,121	$ 1,623,121		$ 278,462	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CAMBRIDGE REALTY		X	MORTGAGE	$82,849.05	11/2/2010	$ 16,102,900	$ 14,817,823	10/1/2052	5.4500	$ 669,577	1
2	LOAN COSTS			AMORT OVER LIFE OF LOAN			130,026	106,309			3,348	2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL	X		WORKING CAPITAL						PRIME+	7,012	6
7	RELATED PARTY	X		WORKING CAPITAL							63,725	7
8	MGMT ALLOCATION										3,195	8
9	TOTAL Facility Related				$82,849.05		$ 16,232,926	$ 14,924,132			$ 746,857	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 16,232,926	$ 14,924,132			$ 746,857	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 84,998 Line # 36

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

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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.)		$ 182,068	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,568	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 180,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 182,568	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	175,323	8
	2016	179,730	9
	2017	175,217	10
	2018	175,911	11
	2019	182,068	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OTTAWA PAVILION COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0039230

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

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 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-13-111-001	NURSING HOME	$ 176,062.92	$ 176,062.92
2.			$	$
3.	10-23-404-059-0000	DYNAMIC HEALTHCARE	$ 36,915.77	$ 6,005.00
4.		ALLOCATION	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 212,978.69	$ 182,067.92

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 1/1/2020 Ending: 12/31/2020

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 # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 392,841	4
5	118				15,864,469		39	412,070	412,070	3,391,960	5
6											6
7	RELATED PARTY				63,873		35	1,825	1,825	40,851	7
8											8
	Improvement Type**										
9	ROOF			2005	30,875		39	791	791	15,378	9
10	POSIFLEX PERSONA URU SCANNER			2011	18,819		39	482	482	5,263	10
11	SIGN			2012	4,243		15	283	283	2,406	11
12	ELECTRICAL, PUMP			2012	2,823		39	72	72	691	12
13	SPRINKLER/FIRE ALARM WORK			2012	4,881		39	125	125	1,184	13
14	CORNER GUARDS, LIGHTING, CURTAINS			2012	6,915		39	178	178	1,683	14
15	MIXING VALVE& FAN MOTORS			2013	9,973		39	256	256	1,868	15
16	CORNER GUARDS			2013	1,837		39	47	47	342	16
17	PLUMBING WORK & SINKS			2013	3,352		39	85	85	622	17
18	ANTENNAS FOR PHONES			2013	1,675		39	43	43	312	18
19	SMOKE DETECTOR			2013	1,005		39	26	26	192	19
20	HEAT PUMP, AC REPAIR, BOOSTER PUMP			2015	14,715		39	366	366	2,019	20
21	WALK IN COOLER REPAIR			2015	4,083		39	106	106	582	21
22	SIGNAGE			2015	2,479		39	63	63	347	22
23	LED HDTV, JUMBO BUTTON REMOTE CONTROLS			2015	1,047		39	28	28	153	23
24	DISPOSER			2015	2,574		39	71	71	388	24
25	PARKING LOT SEAL & STRIPE			2015	2,617		39	71	71	389	25
26	HEAT PUMP			2016	982		39	25	25	125	26
27	DOOR CLOSERS			2016	1,294		39	28	28	140	27
28	AIR DUCT & FIRE DAMPERS			2016	5,986		39	66	66	330	28
29	PARKING LOT SEAL & STRIPE			2016	2,342		39	39	39	195	29
30	RIVER ROCK			2016	1,193		39	20	20	100	30
31	NURSE CALL LIGHT			2016	2,732		39	12	12	60	31
32	SPRINKLER SYSTEM REPAIR			2017	8,227		39	105	105	525	32
33	AC CONDENSOR			2017	7,400		39	95	95	475	33
34	ELECTRICAL OUTLETS/CALL LIGHT BOX			2017	7,400		39	95	95	475	34
35	DOOR CLOSERS			2017	1,768		39	23	23	115	35
36	ROOF REPAIR			2017	3,800		39	49	49	245	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: 1/1/2020 Ending: 12/31/2020

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	$ 60	37
38	REPLACED 2 BOARDS ON RTU, FAN RELAY ON A/C	2020	3,046		39	20	20	20	38
39	REPLACE THE EXISTING JOCKEY PUMP ONSITE	2020	2,950		39	19	19	19	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			423,925			(423,925)		64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 16,642,175	$ 423,925		$ 431,710	$ 7,785	$ 3,862,355	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: 1/1/2020 Ending: 12/31/2020

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	$ 246,708	$ 12,372	$ 24,671	$ 12,299	10	$ 156,205	71
72	Current Year Purchases	2,889	413	144	(269)		144	72
73	Fully Depreciated Assets							73
74	RELATED PARTY			464	464			74
75	TOTALS	$ 249,597	$ 12,785	$ 25,279	$ 12,494		$ 156,349	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	$ 5,001	76
77										77
78	RELATED PARTY									78
79										79
80	TOTALS			$ 31,577	$	$ 1,667	$ 1,667		$ 5,001	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)	$ 18,730,288	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 436,710	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 458,656	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 21,946	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,023,705	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: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

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: $ 50,234 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	$ 2,464	17
18	ADMINISTRATIVE	2018 BUICK ENCORE	228.24	2,739	18
19	FACILITY	2019 FORD E350 ELKART	948.00	10,227	19
20					20
21	TOTAL		$ #######	$ 15,430	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: 1/1/2020 Ending: 12/31/2020

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				153,482		153,482	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					54,337		0 54,337	13
14	TOTAL			$		$	$ 207,819		$ 207,819	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: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (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	$ 2,106,091	$ 2,302,676	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 161,318)	3,828,410	3,828,410	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	138,049	212,251	6
7	Other Prepaid Expenses	2,777	2,777	7
8	Accounts Receivable (owners or related parties)	1,495,785	(296,787)	8
9	Other(specify): ESCROWS		862,409	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,571,112	$ 6,911,736	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	160,437	160,437	15
16	Equipment, at Historical Cost	249,594	1,829,164	16
17	Accumulated Depreciation (book methods)	(259,413)	(5,183,472)	17
18	Deferred Charges	16,844	16,844	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Security Deposits	23,536	23,536	22
23	Other(specify): CLSOING COSTS		106,309	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 190,998	$ 14,624,226	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,762,110	$ 21,535,962	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 711,525	$ 711,525	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,874,938	2,089,550	29
30	Accrued Salaries Payable	353,165	353,165	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,192	7,192	31
32	Accrued Real Estate Taxes(Sch.IX-B)		179,997	32
33	Accrued Interest Payable		55,444	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)**	$ 2,946,820	$ 3,396,873	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,580,638	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)**	$	$ 15,580,638	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,946,820	$ 18,977,511	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,815,290	$ 2,558,451	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,762,110	$ 21,535,962	48

*(See instructions.)

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,010,922	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,010,922	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,563,511	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES	(759,143)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,804,368	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)**	$ 4,815,290	24 *

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 13,111,397	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,111,397	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	250,198	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 250,198	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	2,797	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6	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)**	$ 2,803	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	42,385	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 42,385	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	STIMULUS PAYMENT	1,196,364	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,196,364	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,603,147	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,632,360	31
32	Health Care	5,395,383	32
33	General Administration	2,861,709	33
	B. Capital Expense		
34	Ownership	1,653,455	34
	C. Ancillary Expense		
35	Special Cost Centers	207,819	35
36	Provider Participation Fee	288,910	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,039,636	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,563,511	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,563,511	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,228,238	44
45	Private Pay - Net Inpatient Revenue	3,358,364	45
46	Medicare - Net Inpatient Revenue	5,524,795	46
47	Other-(specify) HOSPICE/INSURANCE/ETC		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,111,397	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: 1/1/2020 Ending: 12/31/2020

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	2,136	2,240	$ 107,718	$ 48.09	1
2	Assistant Director of Nursing	2,088	2,320	87,755	37.83	2
3	Registered Nurses	29,948	31,345	1,023,043	32.64	3
4	Licensed Practical Nurses	18,390	19,726	547,992	27.78	4
5	CNAs & Orderlies	109,658	116,304	1,836,373	15.79	5
6	CNA Trainees					6
7	Licensed Therapist	19,881	21,270	747,802	35.16	7
8	Rehab/Therapy Aides	530	597	7,494	12.55	8
9	Activity Director	2,128	2,320	41,153	17.74	9
10	Activity Assistants	8,798	9,934	102,628	10.33	10
11	Social Service Workers	3,236	3,494	60,254	17.24	11
12	Dietician					12
13	Food Service Supervisor	7,314	7,928	127,590	16.09	13
14	Head Cook	1,900	2,017	21,869	10.84	14
15	Cook Helpers/Assistants	11,760	12,710	140,462	11.05	15
16	Dishwashers					16
17	Maintenance Workers	4,679	5,088	120,243	23.63	17
18	Housekeepers	24,574	27,503	315,181	11.46	18
19	Laundry	854	2,183	17,924	8.21	19
20	Administrator	2,136	2,160	128,314	59.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	336	473	7,482	15.82	23
24	Clerical	9,459	10,036	160,676	16.01	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	484	496	6,365	12.83	31
32	Other Health C: Care Plan Coord	4,370	4,742	162,205	34.21	32
33	Other(specify) ADMITTING	2,040	2,240	64,586	28.83	33
34	TOTAL (lines 1 - 33)	266,699	287,126	$ 5,835,109 *	$ 20.32	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	$ 19,288	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	84,048	10-3	38
39	Pharmacist Consultant	H	9,068	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	1,614	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)		$ 120,018		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	27	1,080	10-3	51
52	Certified Nurse Assistants/Aides	9,145	237,766	10-3	52
53	TOTAL (lines 50 - 52)	9,172	$ 238,846		53

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LAUREN WETZEL	ADMINISTRATOR	0	$ 128,314
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 128,314

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 SCHEDULE ATTACHED		178,274
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 178,274

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 163,675
Unemployment Compensation Insurance	28,394
FICA Taxes	434,142
Employee Health Insurance	212,188
Employee Meals	8,491
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	42,496
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)	$ 889,386

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	$
Advertising: Employee Recruitment	23,180
Health Care Worker Background Check	644
(Indicate # of checks performed)	
Patient Background Checks	7,077
TRUST/FRANCHISE/CONTRIB/ETC	15,626
MARKETING/ADV/PROMO	77,567
LICENSES/DUES/SUBSCRIPTIONS	27,725
MGMT CO ALLOC	2,918
TRUST/FRANCHISE/CONTRIB/ETC	(15,626)
Less: Public Relations Expense	(0)
Non-allowable advertising	(77,567)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 61,544

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,561
MGMT CO ALLOC	382
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,943

* Attach copy of IMRF notifications

**See instructions.

OTTAWA PAVILION
SCHEDULE - LEGAL
12/31/2020

DATE	FIRM NAME	DESCRIPTION	AMOUNT
1/1/2020	MUCH SHELIST	GENERAL COUNSELING	1,170
3/1/2020	MUCH SHELIST	GENERAL COUNSELING	82
4/1/2020	MUCH SHELIST	EMPLOYMENT ISSUES	507
4/1/2020	MUCH SHELIST	GENERAL COUNSELING	82
11/13/2020	MUCH SHELIST	GENERAL COUNSELING	534
1/31/2020	STONE POGRUND & KOREY LLC	GENERAL LITIGATION & COLLECTIONS	158
2/29/2020	STONE POGRUND & KOREY LLC	GENERAL LITIGATION & COLLECTIONS	248
3/31/2020	STONE POGRUND & KOREY LLC	GENERAL LITIGATION & COLLECTIONS	203
4/30/2020	STONE POGRUND & KOREY LLC	GENERAL LITIGATION & COLLECTIONS	119
6/30/2020	STONE POGRUND & KOREY LLC	GENERAL LITIGATION & COLLECTIONS	510
7/31/2020	STONE POGRUND & KOREY LLC	GENERAL LITIGATION & COLLECTIONS	207
8/31/2020	STONE POGRUND & KOREY LLC	GENERAL LITIGATION & COLLECTIONS	135
9/30/2020	STONE POGRUND & KOREY LLC	GENERAL LITIGATION & COLLECTIONS	788
11/30/2020	STONE POGRUND & KOREY LLC	GENERAL LITIGATION & COLLECTIONS	685
4/21/2020	VON BRIESEN	LABOR & EMPLOYMENT	98
5/17/2020	VON BRIESEN	LABOR & EMPLOYMENT	1,199
7/27/2020	VON BRIESEN	LABOR & EMPLOYMENT	133
	TOTAL		**6,856**

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 - $ 6,176**

(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. $ **33,330** 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. $ **288,910**
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. $ **8,491** 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.