

Facility Name & ID Number OTTAWA PAVILION

0039230 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 06/11/2013

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	129	Skilled (SNF)	129	47,085	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	129	TOTALS	129	47,085	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	839	7,078	10,459	18,376	8
9	SNF/PED					9
10	ICF	16,125	8,171	1,200	25,496	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,964	15,249	11,659	43,872	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.18%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

Date started 12/01/1993

J. Was the facility purchased or leased after January 1, 1978?

YES Date 12/01/1993 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 129 and days of care provided 9,554

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	235,404	26,985	9,156	271,545		271,545		271,545		1
2	Food Purchase		274,833		274,833		274,833	(3,462)	271,371		2
3	Housekeeping	246,497	43,115		289,612		289,612		289,612		3
4	Laundry	83,281	12,894	1,028	97,203		97,203		97,203		4
5	Heat and Other Utilities			182,813	182,813		182,813	1,144	183,957		5
6	Maintenance	101,474	45,498	32,348	179,320		179,320	13,608	192,928		6
7	Other (specify):*			9,899	9,899		9,899	926	10,825		7
8	TOTAL General Services	666,656	403,325	235,244	1,305,225		1,305,225	12,216	1,317,441		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	2,694,911	104,285	36,144	2,835,340		2,835,340		2,835,340		10
10a	Therapy	674,487	4,789	31,222	710,498		710,498		710,498		10a
11	Activities	134,262	18,021	3,260	155,543		155,543		155,543		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,503,660	127,095	76,626	3,707,381		3,707,381		3,707,381		16
	C. General Administration										
17	Administrative	87,890		166,774	254,664		254,664	(19,095)	235,569		17
18	Directors Fees										18
19	Professional Services			83,942	83,942		83,942	1,196	85,138		19
20	Dues, Fees, Subscriptions & Promotions			101,785	101,785		101,785	(64,682)	37,103		20
21	Clerical & General Office Expenses	250,552	37,831	432,219	720,602		720,602	(286,490)	434,112		21
22	Employee Benefits & Payroll Taxes			602,589	602,589		602,589		602,589		22
23	Inservice Training & Education			3,268	3,268		3,268		3,268		23
24	Travel and Seminar							1,044	1,044		24
25	Other Admin. Staff Transportation			18,542	18,542		18,542	3,753	22,295		25
26	Insurance-Prop.Liab.Malpractice			126,894	126,894		126,894	(1,297)	125,597		26
27	Other (specify):*			45,471	45,471		45,471	(2,272)	43,199		27
28	TOTAL General Administration	338,442	37,831	1,581,484	1,957,757		1,957,757	(367,843)	1,589,914		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,508,758	568,251	1,893,354	6,970,363		6,970,363	(355,627)	6,614,736		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	9,156
	REPAIRS & MAINTENANCE	0
		9,156
3	HOUSEKEEPING	
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,028
		1,028
5	HEAT & OTHER UTILITIES	
	GAS HEAT	28,813
	ELECTRICITY	114,964
	WATER	34,972
	CABLE TV - LOBBY	4,064
		182,813
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,776
	PAINTING & DECORATING	801
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	18,582
	ELEVATOR MAINTENANCE & REPAIR	4,989
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,200
	FIRE SERVICE	0
		32,348
7	OTHER	
	SCAVENGER	9,899
	SECURITY SERVICE	0
		9,899
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	26,570
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	9,574
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		36,144
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	23,712
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	7,510
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		31,222
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,260
		3,260
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

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	166,774
		166,774
18	DIRECTORS FEES	
	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	46,604
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	37,338
		83,942
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	64,989
	EMPLOYEE WANT ADS XIX F	15,689
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	3,577
	LICENSES & PERMITS XIX F	7,889
	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	2,599
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	7,042
	PATIENT BACKGROUND CHECKS XIX F	0
		101,785
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	15,879
	EQUIPMENT REPAIR & MAINTENANCE	27,123
	OUTSIDE CLERICAL SERVICES	367,100
	PENALTIES / OVERDRAFT CHARGES VI 18	1,208
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	20,909
	MESSENGER SERVICE	0
		432,219

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	344,591
	UNEMPLOYMENT COMPENSATION XIX D	64,254
	WORKERS COMPENSATION INSURANC XIX D	108,942
	HOSPITALIZATION INSURANCE XIX D	71,803
	EMPLOYEE BENEFITS - OTHER XIX D	12,999
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		602,589
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,268
		3,268
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	18,542
		18,542
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	126,894
		126,894
27	OTHER	
	BAD DEBTS VI 24	45,471
		45,471

GRAND TOTAL COLUMN 3 OTHER **1,893,354**

OTTAWA PAVILION
SCHEDULES
12/31/2014

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

TOTAL FOOD PURCHASE	274,833
LESS SALES TAX	<u>(3,462)</u>
NET FOOD	271,371
TOTAL PATIENT CENSUS	43,872
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	131,616
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	131,616
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	131,616
NET FOOD	271,371
DIVIDE TOTAL MEALS/YEAR	<u>131,616</u>
COST PER MEAL	2.06
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

Facility Name & ID Number OTTAWA PAVILION

#0039230

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			32,717	32,717		32,717	(27,521)	5,196			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93,087	93,087		93,087	(21,514)	71,573			32
33	Real Estate Taxes							3,915	3,915			33
34	Rent-Facility & Grounds			1,732,296	1,732,296		1,732,296	(1,732,296)				34
35	Rent-Equipment & Vehicles			33,923	33,923		33,923	10,569	44,492			35
36	Other (specify):*											36
37	TOTAL Ownership			1,892,023	1,892,023		1,892,023	(1,766,847)	125,176			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		262,669	12,316	274,985		274,985		274,985			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			278,903	278,903		278,903		278,903			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		262,669	291,219	553,888		553,888		553,888			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,508,758	830,920	4,076,596	9,416,274		9,416,274	(2,122,474)	7,293,800			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(29,798)	30		9
10	Interest and Other Investment Income	(23,468)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,462)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,208)	21		18
19	Entertainment		20		19
20	Contributions	(2,599)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(268)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(45,471)	27		24
25	Fund Raising, Advertising and Promotional	(64,989)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (171,263)		\$	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	2	
		Amount	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)	(1,951,211)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,951,211)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (2,122,474)		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	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

OTTAWA PAVILION

ID# 0039230

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

Reference

NON-ALLOWABLE EXPENSES

Amount

1	MARKETING SALARY	\$	1
2	MARKETING TRAVEL		2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OTTAWA PAVILION

0039230

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,462)	0	0	0	0	0	0	0	0	0	0	(3,462)	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	1,144	0	0	0	0	0	0	0	0	1,144	5
6	Maintenance	0	0	6,803	6,805	0	0	0	0	0	0	0	13,608	6
7	Other (specify):*	0	0	220	0	706	0	0	0	0	0	0	926	7
8	TOTAL General Services	(3,462)	0	8,167	6,805	706	0	0	0	0	0	0	12,216	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	(166,774)	0	147,679	0	0	0	0	0	0	0	(19,095)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(268)	0	1,464	0	0	0	0	0	0	0	0	1,196	19
20	Fees, Subscriptions & Promotions	(67,588)	0	2,906	0	0	0	0	0	0	0	0	(64,682)	20
21	Clerical & General Office Expenses	(1,208)	(367,100)	72,316	9,502	0	0	0	0	0	0	0	(286,490)	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	1,044	0	0	0	0	0	0	0	0	1,044	24
25	Other Admin. Staff Transportation	0	0	3,753	0	0	0	0	0	0	0	0	3,753	25
26	Insurance-Prop.Liab.Malpractice	0	0	(1,297)	0	0	0	0	0	0	0	0	(1,297)	26
27	Other (specify):*	(45,471)	0	12,850	0	30,349	0	0	0	0	0	0	(2,272)	27
28	TOTAL General Administration	(114,535)	(533,874)	93,036	157,181	30,349	0	0	0	0	0	0	(367,843)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(117,997)	(533,874)	101,203	163,986	31,055	0	0	0	0	0	0	(355,627)	29

STATE OF ILLINOIS

Facility Name & ID Number OTTAWA PAVILION# 0039230

Report Period Beginning:

01/01/2014 Ending:

Summary B

12/31/2014

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(29,798)	0	2,277	0	0	0	0	0	0	0	0	(27,521)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(23,468)	0	1,954	0	0	0	0	0	0	0	0	(21,514)	32
33	Real Estate Taxes	0	0	3,915	0	0	0	0	0	0	0	0	3,915	33
34	Rent-Facility & Grounds	0	(1,732,296)	0	0	0	0	0	0	0	0	0	(1,732,296)	34
35	Rent-Equipment & Vehicles	0	0	10,569	0	0	0	0	0	0	0	0	10,569	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(53,266)	(1,732,296)	18,715	0	0	0	0	0	0	0	0	(1,766,847)	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)	(171,263)	(2,266,170)	119,918	163,986	31,055	0	0	0	0	0	0	(2,122,474)	45

VII. RELATED PARTIES

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

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEES	\$ 166,774	DYNAMIC HEALTH CARE CONSULTANTS		\$	\$ (166,774)	1
2	V	21 BOOKKEEPING SERVICES	367,100	" "			(367,100)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	1,732,296	800 E. CENTER ST			(1,732,296)	7
8	V	30 DEPRECIATION		" "				8
9	V	32 INTEREST		" "				9
10	V	33 REAL ESTATE TAXES		" "				10
11	V	19 LEGAL & ACCOUNTING		" "				11
12	V							12
13	V							13
14	Total		\$ 2,266,170			\$	\$ * (2,266,170)	14

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	\$ 1,144	\$ 1,144
16	V	6 REPAIR & MAINT.		"		6,803	6,803
17	V	7 EMP BEN-GEN SERV		"		220	220
18	V	19 PROFESSIONAL FEES		"		974	974
19	V	20 DUES AND SUBSCRIPTION		"		2,906	2,906
20	V	21 CLERICAL & GENERAL		"		72,316	72,316
21	V	24 SEMINARS AND TRAVEL		"		1,044	1,044
22	V	25 AUTO EXPENSE		"		3,753	3,753
23	V	26 INSURANCE		"		(1,297)	(1,297)
24	V	27 EMP. BEN. - GEN, ADMIN.		"		12,850	12,850
25	V	30 DEPRECIATION		"		2,277	2,277
26	V	32 INTEREST		"		1,954	1,954
27	V	33 REAL ESTATE TAXES		"		3,915	3,915
28	V	19 REAL ESTATE TAX PROTEST FEES		"		490	490
29	V	35 AUTO RENTAL		"		10,491	10,491
30	V	35 EQUIPMENT RENTAL		"		78	78
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 119,918	\$ * 119,918

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 MAINT COMP - D NEHMER	\$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	\$ 6,805	\$ 6,805
16	V	17 ADMIN COMP - M MAUER		"		20,418	20,418
17	V	17 ADMIN COMP - M AARON		"		22,959	22,959
18	V	17 ADMIN COMP - F AARON		"			
19	V	17 ADMIN COMP - D AARON		"			
20	V	17 ADMIN COMP - S GOLDSTEIN		"		38,698	38,698
21	V	17 ADMIN COMP - S HARAMARAS		"			
22	V	17 ADMIN COMP - D KUFTA		"		17,246	17,246
23	V	17 ADMIN COMP - HOWARD ALTER		"			
24	V	17 ADMIN COMP - NON OWNER - V DAVIS		"		13,029	13,029
25	V	17 ADMIN COMP - NON OWNER - VAR		"		14,913	14,913
26	V	17 ADMIN COMP - NON OWNER - CFO		"		20,416	20,416
27	V	21 CLERICAL COMP - S AARON		"		8,884	8,884
28	V	21 CLERICAL COMP - E MARYLES		"		618	618
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 163,986	\$ * 163,986

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	7 EMP BEN - D NEHMER	\$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	\$ 706	\$	706	15
16	V	27 EMP BEN - M MAUER		"		1,174		1,174	16
17	V	27 EMP BEN - M AARON		"		1,653		1,653	17
18	V	27 EMP BEN - F AARON		"					18
19	V	27 EMP BEN - D AARON		"					19
20	V	27 EMP BEN - S GOLDSTEIN		"		13,887		13,887	20
21	V	27 EMP BEN - S HARAMARAS		"					21
22	V	27 EMP BEN - D KUFTA		"		1,234		1,234	22
23	V	27 EMP BEN - HOWARD ALTER		"					23
24	V	27 EMP BEN - V DAVIS		"		3,160		3,160	24
25	V	27 EMP BEN - NON OWNER		"		4,731		4,731	25
26	V	27 EMP BEN - NON OWNER - CFO		"		2,475		2,475	26
27	V	27 EMP BEN - S AARON		"		1,719		1,719	27
28	V	27 EMP BEN - E MARYLES		"		316		316	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		\$			\$ 31,055	\$ *	31,055	39

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

Facility Name & ID Number

OTTAWA PAVILION

0039230

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	MAURICE AARON	26.04	BRADLEY		800 E CENTER STREET		BUILDING CO	1
2	MARSHALL MAUER	14.70	BRIDGEVIEW HEALTH CARE CENTER LTD		DYNAMIC HEALTH	SKOKIE	BOOKKEEPING/C	2
3	SHIMON GOLDSTEIN	.84	GROSS POINTE MANOR LLC		SEASONS HOSPICE		HOSPICE	3
4	FRED AARON	13.03	PARK RIDGE CARE CENTER LTD					4
5	SUSIE ALTER	1.04	STERLING PAVILION LTD					5
6	SUSAN KOPLIN HARAMARAS	.53	WARREN PARK HEALTH AND LIVING CENTER LLC					6
7	DENNIS NEHMER	.53	WATERFRONT TERRACE INC					7
8	SHARON AARON	.53	WINDMILL NURSING PAVILION LTD					8
9	DIANA KUFTA	.53	WOODBIDGE NURSING PAVILION LTD					9
10	SYLVIA AARON	.21	WOODRIDGE SUPPORTING LIVING RESIDENCE OF GALESBURG					10
11	CHANA MAUER-RAY	5.67	WOODRIDGE SUPPORTING LIVING RESIDENCE OF GENESEO					11
12	ESTHER MAUER MARYLES	5.67	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PPONTIAC					12
13	FRANCES MAUER	7.56						13
14	ABRAHAM STERN	15.54						14
15	DEVORA GOLDSTEIN	7.56						15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MAURY AARON	SHAREHOLDER	ADMINISTRATIVE			4.59	9.18		\$ 22,959	17-7	1
2	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIVE		SCHEDULE	4.08	8.17		20,418	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL		ATTACHED	4.08	10.21		8,884	21-7	3
4	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE			4.59	11.48		6,805	6-7	4
5	DIANA KUFTA	SHAREHOLDER	ADMINISTRATIVE			5.74	11.48		17,246	17-7	5
6	S GOLDSTEIN	SHAREHOLDER	ADMINISTRATIVE			15			38,698	17-7	6
7	ESTHER MARYLES	SHAREHOLDER	CLERICAL			0.29	1.02		618	21-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 115,628		13

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

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

Facility Name & ID Number OTTAWA PAVILION

0039230 Report Period Beginning: 01/01/2014

Ending: 2/31/2014

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 NO

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	452,396	12	\$ 11,795	\$ 43,872	\$ 1,144	1
2	6	REPAIR & MAINT.	PATIENT DAYS	452,396	12	70,149	38,885	43,872	6,803
3	7	EMP BEN-GEN SERV	PATIENT DAYS	452,396	12	2,266	43,872	220	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	452,396	12	10,039	43,872	974	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	452,396	12	29,965	43,872	2,906	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	452,396	12	745,706	528,878	43,872	72,316
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	452,396	12	10,766	43,872	1,044	7
8	25	AUTO EXPENSE	PATIENT DAYS	452,396	12	38,698	43,872	3,753	8
9	26	INSURANCE	PATIENT DAYS	452,396	12	(13,379)	43,872	(1,297)	9
10	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	452,396	12	132,506	43,872	12,850	10
11	30	DEPRECIATION	PATIENT DAYS	452,396	12	23,478	43,872	2,277	11
12	32	INTEREST	PATIENT DAYS	452,396	12	20,148	43,872	1,954	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	452,396	12	40,366	43,872	3,915	13
14	19	REAL ESTATE TAX PROTEST FE	PATIENT DAYS	452,396	12	5,056	43,872	490	14
15	35	AUTO RENTAL	PATIENT DAYS	452,396	12	108,178	43,872	10,491	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	452,396	12	802	43,872	78	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,236,539	\$ 567,763	\$ 119,918	25

Facility Name & ID Number OTTAWA PAVILION

0039230 Report Period Beginning: 01/01/2014

Ending: 2/31/2014

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 NO

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	9	\$ 59,284	\$ 59,284	5	\$ 6,805	1
2	6	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	4	20,418	2
3	7	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	9	200,000	200,000	5	22,959	3
4	19	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	11,000	11,000			4
5	20	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	60,271	60,271			5
6	21	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	103,196	103,196	15	38,698	6
7	24	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	76,737	76,737			7
8	25	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	9	150,258	150,258	6	17,246	8
9	27	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			9
10	30	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	11	127,632	127,632	4	13,007	10
11	32	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	9	129,197	129,197	5	14,913	11
12	33	ADMIN COMP - NON OWNER - CE	WGHTD AVG HOURS	40	11	200,000	200,000	4	20,416	12
13	35	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	11	87,119	87,119	4	8,884	13
14	35	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	60,541	60,541	0	618	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,477,235	\$ 1,477,235		\$ 163,964	25

Facility Name & ID Number OTTAWA PAVILION

0039230 Report Period Beginning: 01/01/2014

Ending: 2/31/2014

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 NO

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	9	\$ 6,150	\$	5	\$ 706	1
2	6	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	11,498		4	1,174	2
3	7	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	9	14,402		5	1,653	3
4	19	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	37,628				4
5	20	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	4,909				5
6	21	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,033		15	13,887	6
7	24	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	4	25,836				7
8	25	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	9	10,754		6	1,234	8
9	27	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,085				9
10	30	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	11	30,956		4	3,160	10
11	32	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	9	40,985		5	4,731	11
12	33	ADMIN COMP - NON OWNER - CE	WGHTD AVG HOURS	40	11	24,244		4	2,475	12
13	35	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	11	16,859		4	1,719	13
14	35	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	12	30,999		0	316	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 293,338	\$		\$ 31,055	25

Facility Name & ID Number

OTTAWA PAVILION

0039230

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	Name of Lender	2		3	4	5	6		8	9	10						
		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	11/1/2010	\$ 16,102,900	\$	10/1/2052	5.4500	\$	1					
2												2					
3												3					
4	RELATED PARTY											93,087					
5	RELATED PARTY	X		WORKING CAPITAL								5					
	Working Capital																
6	MB FINANCIAL		X	WORKING CAPITAL								6					
7	M.MAUER / M.AARON	X		WORKING CAPITAL								7					
8	PHARMACY		X	PAYABLE FINANCING								8					
9	TOTAL Facility Related				\$82,849.05		\$ 16,102,900	\$			\$ 93,087	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	\$			\$ 93,087	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2013 report.	\$			1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	124,901		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	124,901		3
4.	Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	124,901		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2009	<u>35,552</u>	8	
		2010	<u>36,798</u>	9	
		2011	<u>37,736</u>	10	
		2012	<u>83,592</u>	11	
		2013	<u>124,901</u>	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED					
ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL					
THE PAYMENT ON LINE 2 APPLIES TO THE 2013 TAX BILL.					
				FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2013	\$			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.

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number OTTAWA PAVILION

0039230 Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>254,390</u>	<u>1998</u>	<u>\$ 1,806,939</u>	1
2					2
3	TOTALS	254,390		\$ 1,806,939	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	17	1998		\$ 550,000	\$	39	\$	\$	4
5	112		2012	15,834,469		39			5
6									6
7									7
8									8
Improvement Type**									
9	ROOF		2005	30,875	1,123	27.5	1,123		9
10	POSIFLEX PERSONA URU SCANNER		2011	18,819	684	27.5	684		10
11	SIGN		2012	4,243	283	15	283		11
12	ELECTRICAL, PUMP		2012	2,823	106	27.5	106		12
13	SPRINKLER/FIRE ALARM WORK		2012	4,881	176	27.5	176		13
14	CORNER GUARDS, LIGHTING, CURTAINS		2012	6,915	250	27.5	250		14
15	MIXING VALVE& FAN MOTORS		2013	9,973	166	27.5	166		15
16	CORNER GUARDS		2013	1,837	30	27.5	30		16
17	PLUMBING WORK & SINKS		2013	3,352	56	27.5	56		17
18	ANTENNAS FOR PHONES		2013	1,675	27	27.5	27		18
19	SMOKE DETECTOR		2013	1,005	18	27.5	18		19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36									36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number OTTAWA PAVILION

0039230

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 16,470,867	\$ 2,919		\$ 2,919	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets		29,798		(29,798)			73
74								74
75	TOTALS	\$	\$ 29,798	\$	\$ (29,798)		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 18,277,806	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,717	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 2,919	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (29,798)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: _____ *

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

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

16. Rental Amount for movable equipment: \$ 26,739 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$ <u>7,184</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>7,184</u>	21

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

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

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2014 Ending: 12/31/2014
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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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				255,870		255,870	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): SUPPLIES, LAB, XRAY					12,316	6,799		19,115	13	
14	TOTAL			\$		\$ 12,316	\$ 262,669		\$ 274,985	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **OTTAWA PAVILION**# **0039230**Report Period Beginning: **01/01/2014**

Ending:

12/31/2014**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2014**

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (<u>80000</u>)	1,848,871		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,186		6
7	Other Prepaid Expenses	9,109		7
8	Accounts Receivable (owners or related parties)	1,493,894		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,455,060	\$	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	102,694		15
16	Equipment, at Historical Cost	149,789		16
17	Accumulated Depreciation (book methods)	(130,220)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	24,892		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 147,155	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,602,215	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 668,569	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,000,000		29
30	Accrued Salaries Payable	325,745		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,511		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	9,539		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)	\$ 2,028,364	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	240,711		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)	\$ 240,711	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,269,075	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,333,140	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,602,215	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 930,408	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 930,408	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	767,732	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	(365,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 402,732	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,333,140	24 *

* This must agree with page 17, line 47.

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,824,407	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,824,407	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	389,527	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 389,527	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	759	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 759	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	23,468	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,468	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		13,653	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,653	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,251,814	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,305,225	31
32	Health Care	3,707,381	32
33	General Administration	1,957,757	33
B. Capital Expense			
34	Ownership	1,892,023	34
C. Ancillary Expense			
35	Special Cost Centers	274,985	35
36	Provider Participation Fee	278,903	36
D. Other Expenses (specify):			
37	<u>OUT-OF-PERIOD EXPENSES</u>	67,808	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,484,082	40
41	Income before Income Taxes (line 30 minus line 40)**	767,732	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 767,732	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,546,421	44
45	Private Pay - Net Inpatient Revenue	2,610,520	45
46	Medicare - Net Inpatient Revenue	4,319,571	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	175,290	47
48	Other-(specify) <u>VETERAN</u>	172,605	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,824,407	49

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

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

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

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

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

Facility Name & ID Number **OTTAWA PAVILION**

0039230

Report Period Beginning: 01/01/2014

Ending:

12/31/2014

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,879	2,088	\$ 77,345	\$ 37.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,328	18,323	493,238	26.92	3
4	Licensed Practical Nurses	30,107	32,079	747,336	23.30	4
5	CNAs & Orderlies	106,247	112,680	1,376,992	12.22	5
6	CNA Trainees					6
7	Licensed Therapist	17,567	18,737	674,487	36.00	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,409	2,749	38,377	13.96	9
10	Activity Assistants	8,523	9,288	95,885	10.32	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,109	2,310	35,392	15.32	13
14	Head Cook	1,478	1,614	22,157	13.73	14
15	Cook Helpers/Assistants	16,280	17,138	177,855	10.38	15
16	Dishwashers					16
17	Maintenance Workers	5,774	6,121	101,474	16.58	17
18	Housekeepers	21,520	23,180	246,497	10.63	18
19	Laundry	7,629	8,278	83,281	10.06	19
20	Administrator	1,962	2,202	87,890	39.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,040	18,403	250,552	13.61	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	257,852	275,190	\$ 4,508,758 *	\$ 16.38	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	181	\$ 9,156	1-3	35
36	Medical Director	96	6,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	192	9,574	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	76	3,260	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	545	\$ 27,990		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	650	26,570	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	650	\$ 26,570		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number OTTAWA PAVILION

0039230

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 \$2,219
- (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? _____ 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. \$ 20,152 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 NO 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. \$ 278,903
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) 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.