

		FOR BHF USE					

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**2016**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2016)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0039230</u></p> <p><b>Facility Name:</b> <u>OTTAWA PAVILION</u></p> <p><b>Address:</b> <u>704 EAST GLOVER ST</u> <u>OTTAWA</u> <u>61350</u>          Number City Zip Code</p> <p><b>County:</b> <u>LASALLE</u></p> <p><b>Telephone Number:</b> <u>(847) 679-8219</u> <b>Fax #</b> <u>(847) 679-7377</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>12/01/1993</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>SANFORD BOKOR</u> <b>Telephone Number:</b> <u>(847) 675-3585</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MARSHALL MAUER</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>TREASURER</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KBKB, LTD</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>      201 S. Grand Avenue East      Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>MARSHALL MAUER</u> (Date) _____		(Title) <u>TREASURER</u>	<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u>	(Firm Name & Address) <u>KBKB, LTD</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number **OTTAWA PAVILION** # **0039230** Report Period Beginning: **01/01/2016** Ending: **12/31/2016**

**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
	<b>A. General Services</b>										
1	Dietary	266,126	25,862	9,156	301,144		301,144		301,144		1
2	Food Purchase		282,084		282,084		282,084	(3,611)	278,473		2
3	Housekeeping	262,384	45,896		308,280		308,280		308,280		3
4	Laundry	59,700	30,240	1,174	91,114		91,114		91,114		4
5	Heat and Other Utilities			179,158	179,158		179,158	1,140	180,298		5
6	Maintenance	86,805	40,203	30,601	157,609		157,609	14,805	172,414		6
7	Other (specify):*			8,777	8,777		8,777	1,012	9,789		7
8	<b>TOTAL General Services</b>	<b>675,015</b>	<b>424,285</b>	<b>228,866</b>	<b>1,328,166</b>		<b>1,328,166</b>	<b>13,346</b>	<b>1,341,512</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	3,011,886	119,166	32,193	3,163,245		3,163,245		3,163,245		10
10a	Therapy	747,546	4,852		752,398		752,398		752,398		10a
11	Activities	149,315	24,012	3,060	176,387		176,387		176,387		11
12	Social Services	62,104		2,127	64,231		64,231		64,231		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,970,851</b>	<b>148,030</b>	<b>43,380</b>	<b>4,162,261</b>		<b>4,162,261</b>		<b>4,162,261</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	98,414		19,991	118,405		118,405	182,426	300,831		17
18	Directors Fees										18
19	Professional Services			126,575	126,575		126,575	22,408	148,983		19
20	Dues, Fees, Subscriptions & Promotions			158,802	158,802		158,802	(61,560)	97,242		20
21	Clerical & General Office Expenses	154,861	33,951	687,627	876,439		876,439	(514,466)	361,973		21
22	Employee Benefits & Payroll Taxes			657,098	657,098		657,098		657,098		22
23	Inservice Training & Education			5,747	5,747		5,747		5,747		23
24	Travel and Seminar							2,126	2,126		24
25	Other Admin. Staff Transportation			8,244	8,244		8,244	1,777	10,021		25
26	Insurance-Prop.Liab.Malpractice			154,676	154,676		154,676	14,827	169,503		26
27	Other (specify):*			69,123	69,123		69,123	(9,289)	59,834		27
28	<b>TOTAL General Administration</b>	<b>253,275</b>	<b>33,951</b>	<b>1,887,883</b>	<b>2,175,109</b>		<b>2,175,109</b>	<b>(361,751)</b>	<b>1,813,358</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,899,141</b>	<b>606,266</b>	<b>2,160,129</b>	<b>7,665,536</b>		<b>7,665,536</b>	<b>(348,405)</b>	<b>7,317,131</b>		<b>29</b>

\*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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	9,156
	REPAIRS & MAINTENANCE	0
		9,156
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	1,174
		1,174
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	12,664
	ELECTRICITY	119,538
	WATER	36,595
	CABLE TV - LOBBY	10,361
		179,158
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	2,743
	PAINTING & DECORATING	1,201
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	17,607
	ELEVATOR MAINTENANCE & REPAIR	5,274
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,776
	FIRE SERVICE	0
		30,601
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	8,777
	SECURITY SERVICE	0
		8,777
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	22,451
	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	9,742
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		32,193
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,060
		3,060
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,127
		2,127
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
		0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	19,991
		19,991
<b>18</b>	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
		0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	62,756
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	63,819
		126,575
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	63,405
	EMPLOYEE WANT ADS XIX F	59,253
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	22,763
	LICENSES & PERMITS XIX F	8,359
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	3,352
	PATIENT BACKGROUND CHECKS XIX F	1,670
		158,802
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	19,063
	EQUIPMENT REPAIR & MAINTENANCE	33,180
	OUTSIDE CLERICAL SERVICES	620,100
	PENALTIES / OVERDRAFT CHARGES VI 18	713
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	14,571
	MESSENGER SERVICE	0
		687,627

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	368,865
	UNEMPLOYMENT COMPENSATION XIX D	69,717
	WORKERS COMPENSATION INSURANCE XIX D	109,749
	HOSPITALIZATION INSURANCE XIX D	93,588
	EMPLOYEE BENEFITS - OTHER XIX D	15,179
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
		657,098
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	5,747
		5,747
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	8,244
		8,244
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	154,676
		154,676
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	69,123
		69,123

GRAND TOTAL COLUMN 3 OTHER

2,160,129

**OTTAWA PAVILION  
SCHEDULES  
12/31/2016**

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

TOTAL FOOD PURCHASE	282,084
LESS SALES TAX	<u>(3,611)</u>
NET FOOD	278,473
TOTAL PATIENT CENSUS	44,625
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	133,875
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	<u>49,410</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	133,875
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	133,875
NET FOOD	278,473
DIVIDE TOTAL MEALS/YEAR	<u>133,875</u>
COST PER MEAL	2.08
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

Facility Name &amp; ID Number

OTTAWA PAVILION

#0039230

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## 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	
	<b>D. Ownership</b>											
30	Depreciation			37,046	37,046		37,046	427,618	464,664			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			85,844	85,844		85,844	663,564	749,408			32
33	Real Estate Taxes							189,817	189,817			33
34	Rent-Facility & Grounds			1,500,000	1,500,000		1,500,000	(1,500,000)				34
35	Rent-Equipment & Vehicles			38,347	38,347		38,347	13,813	52,160			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,661,237	1,661,237		1,661,237	(205,188)	1,456,049			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		274,187		274,187		274,187		274,187			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			288,236	288,236		288,236		288,236			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		274,187	288,236	562,423		562,423		562,423			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,899,141	880,453	4,109,602	9,889,196		9,889,196	(553,593)	9,335,603			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(291,714)	30		9
10	Interest and Other Investment Income	(42,494)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,611)	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	(713)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(69,123)	27		24
25	Fund Raising, Advertising and Promotional	(63,405)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PG 5A	(19,096)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (490,156)		\$	30

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	(63,437)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (63,437)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (553,593)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	

OTTAWA PAVILION

ID# 0039230

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (19,096)	21	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
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(19,096)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## 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	(3,611)	0	0	0	0	0	0	0	0	0	0	(3,611)	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	1,140	0	0	0	0	0	0	0	0	1,140	5
6	Maintenance	0	0	7,296	7,509	0	0	0	0	0	0	0	14,805	6
7	Other (specify):*	0	0	234	0	778	0	0	0	0	0	0	1,012	7
8	<b>TOTAL General Services</b>	<b>(3,611)</b>	<b>0</b>	<b>8,670</b>	<b>7,509</b>	<b>778</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>13,346</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(19,991)	0	202,417	0	0	0	0	0	0	0	182,426	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,000	6,408	0	0	0	0	0	0	0	0	22,408	19
20	Fees, Subscriptions & Promotions	(63,405)	0	1,845	0	0	0	0	0	0	0	0	(61,560)	20
21	Clerical & General Office Expenses	(19,809)	(620,100)	114,700	10,743	0	0	0	0	0	0	0	(514,466)	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	2,126	0	0	0	0	0	0	0	0	2,126	24
25	Other Admin. Staff Transportation	0	0	1,777	0	0	0	0	0	0	0	0	1,777	25
26	Insurance-Prop.Liab.Malpractice	0	11,429	3,398	0	0	0	0	0	0	0	0	14,827	26
27	Other (specify):*	(69,123)	0	19,203	0	40,631	0	0	0	0	0	0	(9,289)	27
28	<b>TOTAL General Administration</b>	<b>(152,337)</b>	<b>(612,662)</b>	<b>149,457</b>	<b>213,160</b>	<b>40,631</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(361,751)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(155,948)</b>	<b>(612,662)</b>	<b>158,127</b>	<b>220,669</b>	<b>41,409</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(348,405)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	(291,714)	716,255	3,077	0	0	0	0	0	0	0	0	427,618	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(42,494)	703,381	2,677	0	0	0	0	0	0	0	0	663,564	32
33	Real Estate Taxes	0	185,323	4,494	0	0	0	0	0	0	0	0	189,817	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	13,813	0	0	0	0	0	0	0	0	13,813	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(334,208)</b>	<b>104,959</b>	<b>24,061</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(205,188)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(490,156)</b>	<b>(507,703)</b>	<b>182,188</b>	<b>220,669</b>	<b>41,409</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(553,593)</b>	<b>45</b>

**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	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)	
1	V	17 MANAGEMENT FEES	\$ 19,991	DYNAMIC HEALTH CARE CONSULTANTS		\$	\$ (19,991)	1
2	V	21 BOOKKEEPING SERVICES	620,100	" "			(620,100)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	1,500,000	800 E. CENTER ST			(1,500,000)	7
8	V	30 DEPRECIATION		" "		716,255	716,255	8
9	V	32 INTEREST		" "		703,381	703,381	9
10	V	33 REAL ESTATE TAXES		" "		185,323	185,323	10
11	V	19 LEGAL & ACCOUNTING		" "		16,000	16,000	11
12	V	26 INSURANCE		" "		11,429	11,429	12
13	V							13
14	Total		\$ 2,140,091			\$ 1,632,388	\$ * (507,703)	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%	\$ 1,140	\$	1,140	15
16	V	6 REPAIR & MAINT.		"		7,296		7,296	16
17	V	7 EMP BEN-GEN SERV		"		234		234	17
18	V	19 PROFESSIONAL FEES		"		6,408		6,408	18
19	V	20 DUES AND SUBSCRIPTION		"		1,845		1,845	19
20	V	21 CLERICAL & GENERAL		"		114,700		114,700	20
21	V	24 SEMINARS AND TRAVEL		"		2,126		2,126	21
22	V	25 AUTO EXPENSE		"		1,777		1,777	22
23	V	26 INSURANCE		"		3,398		3,398	23
24	V	27 EMP. BEN. - GEN, ADMIN.		"		19,203		19,203	24
25	V	30 DEPRECIATION		"		3,077		3,077	25
26	V	32 INTEREST		"		2,677		2,677	26
27	V	33 REAL ESTATE TAXES		"		4,494		4,494	27
28	V	19 REAL ESTATE TAX PROTEST FEES		"					28
29	V	35 AUTO RENTAL		"		12,927		12,927	29
30	V	35 EQUIPMENT RENTAL		"		886		886	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		\$			\$ 182,188	\$ *	182,188	39

\* 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%	\$ 7,509	\$ 7,509
16	V	17 ADMIN COMP - M MAUER		"		22,575	22,575
17	V	17 ADMIN COMP - M AARON		"		25,748	25,748
18	V	17 ADMIN COMP - F AARON		"			
19	V	17 ADMIN COMP - D AARON		"			
20	V	17 ADMIN COMP - S GOLDSTEIN		"		68,563	68,563
21	V	17 ADMIN COMP - B FREIDMAN		"			
22	V	17 ADMIN COMP - R AARON		"			
23	V	17 ADMIN COMP - S HARAMARAS		"			
24	V	17 ADMIN COMP - D KUFTA		"		18,989	18,989
25	V	17 ADMIN COMP - HOWARD ALTER		"			
26	V	17 ADMIN COMP - NON OWNER - V DAVIS		"		15,015	15,015
27	V	17 ADMIN COMP - NON OWNER - CASSATA		"			
28	V	17 ADMIN COMP - NON OWNER - VAR		"		23,837	23,837
29	V	17 ADMIN COMP - NON OWNER - CFO		"		27,690	27,690
30	V	21 CLERICAL COMP - S AARON		"		10,037	10,037
31	V	21 CLERICAL COMP - E MARYLES		"		706	706
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 220,669	\$ * 220,669

\* 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%	\$ 778	\$ 778	15
16	V	27 EMP BEN - M MAUER		"		4,683	4,683	16
17	V	27 EMP BEN - M AARON		"		4,881	4,881	17
18	V	27 EMP BEN - F AARON		"				18
19	V	27 EMP BEN - D AARON		"				19
20	V	27 EMP BEN - S GOLDSTEIN		"		13,785	13,785	20
21	V	27 EMP BEN - B FREIDMAN		"				21
22	V	27 EMP BEN - R AARON		"				22
23	V	27 EMP BEN - S HARAMARAS		"				23
24	V	27 EMP BEN - D KUFTA		"		1,336	1,336	24
25	V	27 EMP BEN - HOWARD ALTER		"				25
26	V	27 EMP BEN - V DAVIS		"		3,793	3,793	26
27	V	27 EMP BEN - A CASSATA		"				27
28	V	27 EMP BEN - NON OWNER		"		6,744	6,744	28
29	V	27 EMP BEN - NON OWNER - CFO		"		2,909	2,909	29
30	V	27 EMP BEN - S AARON		"		2,065	2,065	30
31	V	27 EMP BEN - E MARYLES		"		435	435	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 41,409	\$ * 41,409	39

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

Facility Name &amp; ID Number

OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## 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 CARE		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	WATERFRONT TERRACE INC					6
7	DENNIS NEHMER	.53	WILLOW CREST					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						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 &amp; ID Number

OTTAWA PAVILION

#

0039230

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## 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			5.15	12.87	SALARY	\$ 25,748	17-7	1
2	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIVE		SCHEDULE	4.51	11.29	SALARY	22,575	17-7	2
3	SHARON AARON	SHAREHOLDER	CLERICAL		ATTACHED	4.51	11.29	SALARY	10,037	21-7	3
4	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE			5.15	12.87	SALARY	7,509	6-7	4
5	DIANA KUFTA	SHAREHOLDER	ADMINISTRATIVE			6.44	12.87	SALARY	18,989	17-7	5
6	S GOLDSTEIN	SHAREHOLDER	ADMINISTRATIVE			15		SALARY	68,563	17-7	6
7	ESTHER MARYLES	SHAREHOLDER	CLERICAL			0.32	1.13	SALARY	706	21-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 154,127		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:

01/01/2016

Ending: 2/31/2016

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

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	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	415,748	11	\$ 10,619	\$ 44,625	\$ 1,140	1	
2	6	REPAIR & MAINT.	PATIENT DAYS	415,748	11	67,972	32,339	44,625	7,296	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	415,748	11	2,182	44,625	234	3	
4	19	PROFESSIONAL FEES	PATIENT DAYS	415,748	11	59,702	44,625	6,408	4	
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	415,748	11	17,185	44,625	1,845	5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	415,748	11	1,068,604	741,401	44,625	114,700	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	415,748	11	19,810	44,625	2,126	7	
8	25	AUTO EXPENSE	PATIENT DAYS	415,748	11	16,560	44,625	1,777	8	
9	26	INSURANCE	PATIENT DAYS	415,748	11	31,660	44,625	3,398	9	
10	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	415,748	11	178,906	44,625	19,203	10	
11	30	DEPRECIATION	PATIENT DAYS	415,748	11	28,663	44,625	3,077	11	
12	32	INTEREST	PATIENT DAYS	415,748	11	24,945	44,625	2,677	12	
13	33	REAL ESTATE TAXES	PATIENT DAYS	415,748	11	41,869	44,625	4,494	13	
14	19	REAL ESTATE TAX PROTEST FE	PATIENT DAYS	415,748	11		44,625	0	14	
15	35	AUTO RENTAL	PATIENT DAYS	415,748	11	120,431	44,625	12,927	15	
16	35	EQUIPMENT RENTAL	PATIENT DAYS	415,748	11	8,254	44,625	886	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,697,362	\$ 773,740	\$ 182,188	25	

Facility Name & ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

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

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	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	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	9	\$ 58,328	\$ 58,328	5	\$ 7,509	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	5	22,575	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	9	200,000	200,000	5	25,748	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	2,500	2,500			4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	76,541	76,541			5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	182,833	182,833	15	68,563	6
7	17	ADMIN COMP - B FREIDMAN	WGHTD AVG HOURS	40	1	200,000	200,000			7
8	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	40	1	60,541	60,541			8
9	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	3	72,895	72,895			9
10	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	8	147,459	147,459	6	18,989	10
11	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			11
12	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	10	133,035	133,035	5	15,015	12
13	17	ADMIN COMP - NON OWNER - A	WGHTD AVG HOURS	40	1	94,167	94,167			13
14	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	45	8	185,179	185,179	6	23,837	14
15	17	ADMIN COMP - NON OWNER - C	WGHTD AVG HOURS	40	10	245,335	245,335	5	27,690	15
16	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	10	89,040	89,040	5	10,037	16
17	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	11	62,541	62,541	0	706	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,022,394	\$ 2,022,394		\$ 220,669	25

Facility Name & ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

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

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	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	7	EMP BEN - D NEHMER	WGHTD AVG HOURS	40	9	\$ 6,047	\$ 5	\$ 778	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	41,488	5	4,683	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	9	37,909	5	4,881	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	39,733			4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	6,379			5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	36,760	15	13,785	6
7	27	EMP BEN - B FREIDMAN	WGHTD AVG HOURS	40	1	10,395			7
8	27	EMP BEN - R AARON	WGHTD AVG HOURS	40	1	4,779			8
9	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	3	27,583			9
10	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	8	10,371	6	1,336	10
11	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,060			11
12	27	EMP BEN - NON OWNER - V DAVI	WGHTD AVG HOURS	40	10	33,608	5	3,793	12
13	27	EMP BEN - NON OWNER - A CASS	WGHTD AVG HOURS	40	1	7,352			13
14	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	8	52,388	6	6,744	14
15	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	10	25,777	5	2,909	15
16	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	10	18,319	5	2,065	16
17	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	11	38,523	0	435	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 398,471	\$	\$ 41,409	25

Facility Name & ID Number

OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	CAMBRIDGE		X	MORTGAGE	\$82,849.05	11/2/2010	\$ 16,102,900	\$ 15,586,243	10/1/2052	5.4500	\$ 703,381	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	MB FINANCIAL		X	WORKING CAPITAL				998,782			41,967	6								
7	RELATED PARTY	X		WORKING CAPITAL							43,875	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$82,849.05		\$ 16,102,900	\$ 16,585,025			\$ 789,223	9								
<b>B. Non-Facility Related*</b>																				
10	IRS,IDR,ETC		X	LATE FEES								10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 16,102,900	\$ 16,585,025			\$ 789,223	15								

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

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

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

**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 2015 report.	\$	<b>169,000</b>	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.)	\$	<b>175,323</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>6,323</b>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>179,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ <u>200</u> For <u>        </u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>185,323</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<b>37,736</b>	8
	2012	<b>83,592</b>	9
	2013	<b>124,901</b>	10
	2014	<b>165,335</b>	11
	2015	<b>175,323</b>	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**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 2015 TAX BILL.**

**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.**

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME OTTAWA PAVILION COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0039230

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>22-13-111-001</u>	<u>NURSING HOME</u>	\$ <u>175,322.80</u>	\$ <u>175,322.80</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>175,322.80</u></u>	\$ <u><u>175,322.80</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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:

01/01/2016 Ending:

12/31/2016

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Row 1: NURSING HOME, 254,390, 1998, \$ 1,806,939, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 254,390, (blank), \$ 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	\$ 14,106	\$ 14,106	\$ 336,417	4
5	118		2012	15,864,469	412,070	39	412,070		1,743,680	5
6										6
7	RELATED PARTY			47,615	1,221	35	1,360	139	31,743	7
8										8
<b>Improvement Type**</b>										
9	ROOF		2005	30,875	791	39	791		12,214	9
10	POSIFLEX PERSONA URU SCANNER		2011	18,819	482	39	482		3,335	10
11	SIGN		2012	4,243	283	15	283		1,274	11
12	ELECTRICAL, PUMP		2012	2,823	72	39	72		403	12
13	SPRINKLER/FIRE ALARM WORK		2012	4,881	125	39	125		684	13
14	CORNER GUARDS, LIGHTING, CURTAINS		2012	6,915	178	39	178		971	14
15	MIXING VALVE& FAN MOTORS		2013	9,973	256	39	256		844	15
16	CORNER GUARDS		2013	1,837	47	39	47		154	16
17	PLUMBING WORK & SINKS		2013	3,352	85	39	85		282	17
18	ANTENNAS FOR PHONES		2013	1,675	43	39	43		140	18
19	SMOKE DETECTOR		2013	1,005	26	39	26		88	19
20	HEAT PUMP, AC REPAIR, BOOSTER PUMP		2015	14,715	366	39	366		555	20
21	WALK IN COOLER REPAIR		2015	4,083	106	39	106		158	21
22	SIGNAGE		2015	2,479	63	39	63		95	22
23	LED HDTV, JUMBO BUTTON REMOTE CONTROLS		2015	1,047	28	39	28		41	23
24	DISPOSER		2015	2,574	71	39	71		104	24
25	PARKING LOT SEAL & STRIPE		2015	2,617	71	39	71		105	25
26	HEAT PUMP		2016	982	25	39	25		25	26
27	DOOR CLOSERS		2016	1,294	28	39	28		28	27
28	AIR DUCT & FIRE DAMPERS		2016	5,986	66	39	66		66	28
29	PARKING LOT SEAL & STRIPE		2016	2,342	39	39	39		39	29
30	RIVER ROCK		2016	1,193	20	39	20		20	30
31	NURSE CALL LIGHT		2016	2,732	12	39	12		12	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

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)	\$ 16,590,526	\$ 416,574		\$ 430,819	\$ 14,245	\$ 2,133,477	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	\$ 172,055	\$ 31,999	\$ 3,200	\$ (28,799)	10	\$ 88,632	71
72	Current Year Purchases	28,630	1,582	158	(1,424)	10	158	72
73	Fully Depreciated Assets							73
74	<b>RELATED PARTY</b>	1,549,644	306,223	30,487	(275,736)	10		74
75	<b>TOTALS</b>	\$ 1,750,329	\$ 339,804	\$ 33,845	\$ (305,959)		\$ 88,790	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	80

**E. Summary of Care-Related Assets**

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 20,147,794	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 756,378	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 464,664	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (291,714)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,222,267	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	<b>TOTALS</b>	\$	\$	\$	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	<b>TOTAL</b>				\$			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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ **26,924** Description: **SEE 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		<b>2014 CHEVY CRUZE</b>	\$ <b>248.00</b>	\$ <b>2,975</b>	17
18			<b>704.00</b>	<b>8,448</b>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>952.00</b>	\$ <b>11,423</b>	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.

**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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units						Cost
					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 prescripts				237,081		237,081	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): _____									12	
13	Other (specify): <b>MED SUPPLIES, LAB, ETC</b>						37,106		37,106	13	
14	<b>TOTAL</b>			\$		\$	\$ 274,187		\$ 274,187	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.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 20,961	\$ 230,881	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>122,000</u> )	2,117,690	2,117,690	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	114,608	187,841	6
7	Other Prepaid Expenses	9,061	9,061	7
8	Accounts Receivable (owners or related parties)	1,765,894	(26,678)	8
9	Other(specify): <u>ESCROWS</u>		542,667	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,028,214	\$ 3,061,462	10
	<b>B. Long-Term Assets</b>			
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	128,447	128,447	15
16	Equipment, at Historical Cost	214,248	1,735,175	16
17	Accumulated Depreciation (book methods)	(158,093)	(3,193,070)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		130,026	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,324)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>SECURITY DEPOSITS</u>	24,892	24,892	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 209,494	\$ 16,486,554	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,237,708	\$ 19,548,016	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 631,881	\$ 632,221	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	998,782	1,178,172	29
30	Accrued Salaries Payable	391,464	391,464	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,020	27,020	31
32	Accrued Real Estate Taxes(Sch.IX-B)		179,000	32
33	Accrued Interest Payable	4,935	63,254	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>MORTGAGE PREMIUM NET</u>		1,182,121	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,054,082	\$ 3,653,252	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,406,853	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 15,406,853	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,054,082	\$ 19,060,105	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,183,626	\$ 487,911	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,237,708	\$ 19,548,016	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,853,810</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ILLINOIS REPLACEMENT TAX</b>	(13,598)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,840,212</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	893,414	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(550,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>OUT OF PERIOD EXPENSES</b>		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>343,414</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,183,626</b>	<b>24</b> *

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

Facility Name &amp; ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,631,449	1
2	Discounts and Allowances for all Levels	(75,214)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,556,235	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	299,463	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 299,463	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	6,279	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 6,279	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	42,494	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 42,494	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>OTHER</b>	13,759	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 13,759	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,918,230	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,328,166	31
32	Health Care	4,162,261	32
33	General Administration	2,175,109	33
<b>B. Capital Expense</b>			
34	Ownership	1,661,237	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	274,187	35
36	Provider Participation Fee	288,236	36
<b>D. Other Expenses (specify):</b>			
37	<b>PRIOR PERIOD EXPENSE</b>	135,620	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,024,816	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	893,414	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 893,414	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,698,913	44
45	Private Pay - Net Inpatient Revenue	3,033,066	45
46	Medicare - Net Inpatient Revenue	4,607,211	46
47	Other-(specify) <b>HOSPICE/INSURANCE/ETC</b>	98,581	47
48	Other-(specify) <b>VETERAN</b>	193,678	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 10,631,449	49

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

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

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

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

Facility Name & ID Number **OTTAWA PAVILION**

# **0039230**

Report Period Beginning:

**01/01/2016**

Ending:

**12/31/2016**

**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	1,904	2,091	\$ 85,411	\$ 40.85	1
2	Assistant Director of Nursing	537	796	21,913	27.53	2
3	Registered Nurses	23,389	25,183	724,263	28.76	3
4	Licensed Practical Nurses	23,322	25,017	623,722	24.93	4
5	CNAs & Orderlies	109,500	116,038	1,556,577	13.41	5
6	CNA Trainees					6
7	Licensed Therapist	18,168	19,468	747,546	38.40	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,043	2,198	32,972	15.00	9
10	Activity Assistants	10,357	10,667	116,343	10.91	10
11	Social Service Workers	3,768	4,273	62,104	14.53	11
12	Dietician					12
13	Food Service Supervisor	1,885	1,998	50,737	25.39	13
14	Head Cook	5,974	6,452	83,414	12.93	14
15	Cook Helpers/Assistants	12,678	13,282	131,975	9.94	15
16	Dishwashers					16
17	Maintenance Workers	4,733	5,141	86,805	16.88	17
18	Housekeepers	22,193	23,777	262,384	11.04	18
19	Laundry	4,481	5,218	59,700	11.44	19
20	Administrator	1,921	2,267	98,414	43.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,147	12,139	154,861	12.76	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)	257,000	276,005	\$ 4,899,141 *	\$ 17.75	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	M	\$ 9,156	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	9,742	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,060	11-3	44
45	Social Service Consultant	E	2,127	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,085		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	320	\$ 12,827	10-3	50
51	Licensed Practical Nurses	228	9,624	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	548	\$ 22,451		53



OTTAWA PAVILION  
LEGAL FEES  
12/31/2016

DATE	NAME	DESCRIPTION	AMOUNT
1/31/2016	MUCH SHELIST	GENERAL COUNSELING	600.00
3/1/2016	MUCH SHELIST	GENERAL COUNSELING	1,298.00
3/31/2016	MUCH SHELIST	GENERAL COUNSELING	1,142.73
4/30/2016	MUCH SHELIST	GENERAL COUNSELING	75.00
8/31/2016	MUCH SHELIST	GENERAL COUNSELING	575.00
9/30/2016	MUCH SHELIST	GENERAL COUNSELING	412.50
10/25/2016	MUCH SHELIST	GENERAL COUNSELING	350.00
10/31/2016	MUCH SHELIST	GENERAL COUNSELING	75.00
11/30/2016	MUCH SHELIST	GENERAL COUNSELING	487.50
12/31/2016	MUCH SHELIST	GENERAL COUNSELING	462.50
2/29/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	89.59
2/29/2016	SIMANDL LAW GROUP	FACILITY AUDITS	241.34
2/28/2015	SIMANDL LAW GROUP	FACILITY CONTACTS	598.50
3/31/2016	SIMANDL LAW GROUP	FACILITY CONTACTS	535.00
4/30/2016	SIMANDL LAW GROUP	FACILITY AUDITS	2,294.50
5/31/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	2,915.50
5/31/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	25.13
5/31/2016	SIMANDL LAW GROUP	FACILITY CONTACTS	28.50
5/31/2016		FACILITY AUDITS	1,140.69
6/30/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	8.18
6/30/2016	SIMANDL LAW GROUP	FACILITY AUDITS	457.05
7/31/2016	SIMANDL LAW GROUP	FACILITY AUDITS	320.41
10/31/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	1.92
10/31/2016	SIMANDL LAW GROUP	FACILITY AUDITS	126.65
10/31/2016	SIMANDL LAW GROUP	GENERAL	14.54
11/30/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	1,136.50
9/15/2016	LAW OFFICE OF FRANK C. KERR	GENERAL	1,550.00
1/31/2016	POLSINELLI	CERTIFICATE OF NEED	442.75
3/7/2016	POLSINELLI	CERTIFICATE OF NEED	38.50
3/31/2016	POLSINELLI	CERTIFICATE OF NEED	154.00
3/31/2016	POLSINELLI	CERTIFICATE OF NEED	8.01
6/30/2016	POLSINELLI	CERTIFICATE OF NEED	201.90
1/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	2,504.00
1/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	21.30
2/19/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	685.20
3/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	2,409.82
4/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	2,030.00
6/1/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	2,042.43
6/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,808.86
7/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,977.50
8/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	980.00
9/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	592.50
10/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	462.50
11/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,007.00
12/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	918.28
			13.33
			<u>35,260.11</u>

Facility Name &amp; ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ICLTC \$12,352
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,157 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. \$ 288,236  
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