

		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.

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

Facility Name & ID Number OTTAWA PAVILION

#	0039230	Report Period Beginning:	01/01/2016	Ending:	12/31/2016
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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

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)

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?

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

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

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

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

YES ☐ NO ☐ If YES, enter number
of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL	☒	MODIFIED		
CASH*	☐	CASH*	☐	

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

Tax Year: 12/31/2016 **Fiscal Year:** 12/31/2016

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

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	135	Skilled (SNF)	135	49,410			1
2		Skilled Pediatric (SNF/PED)					2
3		Intermediate (ICF)					3
4		Intermediate/DD					4
5		Sheltered Care (SC)					5
6		ICF/DD 16 or Less					6
7	135	TOTALS	135	49,410			7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	187	1,717	9,346	11,250	8
9	SNF/PED					9
10	ICF	17,800	13,851	1,724	33,375	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,987	15,568	11,070	44,625	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.32%

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	
	A. General Services											
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	TOTAL General Services	675,015	424,285	228,866	1,328,166		1,328,166	13,346	1,341,512			8
	B. Health Care and Programs											
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	TOTAL Health Care and Programs	3,970,851	148,030	43,380	4,162,261		4,162,261		4,162,261			16
	C. General Administration											
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	TOTAL General Administration	253,275	33,951	1,887,883	2,175,109		2,175,109	(361,751)	1,813,358			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,899,141	606,266	2,160,129	7,665,536		7,665,536	(348,405)	7,317,131			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	LINE		SCHED REF	TOTAL
1	DIETARY			10	NURSING		
	DIETITIAN CONSULTANT	XVIII B 35-2	9,156		CONTRACT NURSING	XVIII C 53-2	22,451
	REPAIRS & MAINTENANCE		0		LABORATORY & XRAY EXPENSE		0
			9,156		PURCHASED SERVICES		0
3	HOUSEKEEPING				PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
			0		RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
			0		MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
4	LAUNDRY				PHARMACY CONSULTANT	XVIII B 39-2	9,742
	EQUIPMENT REPAIRS & MAINTENANCE		1,174		UTILIZATION REVIEW FEES	XVIII B __-2	0
			1,174		PHYSICIANS	XVIII B __-2	0
5	HEAT & OTHER UTILITIES				PSYCHIATRIC	XVIII B __-2	0
	GAS HEAT		12,664		RN CONSULTANT	XVIII B 38-2	0
	ELECTRICITY		119,538				
	WATER		36,595				32,193
	CABLE TV - LOBBY		10,361	10a	THERAPY		
			179,158		PHYSICAL THERAPY SERVICES		0
6	MAINTENANCE				SPEECH THERAPY SERVICES		0
	GROUNDS MAINTENANCE		2,743		OCCUPATIONAL THERAPY SERVICES		0
	PAINTING & DECORATING		1,201		REHABILITATION CONSULTANT	XVIII B __-2	0
	BUILDING REPAIRS		0		PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	MAINTENANCE TRAVEL		0		OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	EQUIPMENT MAINTENANCE & REPAIR		17,607		RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	ELEVATOR MAINTENANCE & REPAIR		5,274		SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
	OUTSIDE LABOR		0				
	EXTERMINATING SERVICE		3,776				0
	FIRE SERVICE		0	11	ACTIVITIES		
					CABLE TV - PATIENT ROOMS		0
					ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,060
			30,601				3,060
7	OTHER			12	SOCIAL SERVICES		
	SCAVENGER		8,777		SOCIAL REHABILITATION SERVICES		0
	SECURITY SERVICE		0		SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
					SOCIAL WORKER	XVIII B 45-2	2,127
			8,777				2,127
9	MEDICAL DIRECTOR			13	NURSE AIDE TRAINING		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000		NURSE AIDE TRAINING COSTS	XIII	0

LINE		SCHED REF	TOTAL	LINE		SCHED REF	TOTAL
10	NURSING			10a	THERAPY		
	CONTRACT NURSING	XVIII C 53-2	22,451		PHYSICAL THERAPY SERVICES		0
	LABORATORY & XRAY EXPENSE		0		SPEECH THERAPY SERVICES		0
	PURCHASED SERVICES		0		OCCUPATIONAL THERAPY SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0		REHABILITATION CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0		PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0		OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	9,742		RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	UTILIZATION REVIEW FEES	XVIII B __-2	0		SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
	PHYSICIANS	XVIII B __-2	0				
	PSYCHIATRIC	XVIII B __-2	0				0
	RN CONSULTANT	XVIII B 38-2	0	11	ACTIVITIES		
					CABLE TV - PATIENT ROOMS		0
					ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,060
							3,060
				12	SOCIAL SERVICES		
					SOCIAL REHABILITATION SERVICES		0
					SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
					SOCIAL WORKER	XVIII B 45-2	2,127
							2,127
				13	NURSE AIDE TRAINING		
					NURSE AIDE TRAINING COSTS	XIII	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	19,991	19,991
	DIRECTORS FEES		
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING XIX C	62,756	
	ADMINISTRATIVE CONSULTANTS XIX C	0	
	PROFESSIONAL FEES XIX C	63,819	
			126,575
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	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
21	CLERICAL & GENERAL OFFICE EXPENSES		
	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
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	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
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	5,747	
			5,747
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS XIX G	0	
	TRAVEL XIX G	0	
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	8,244	
			8,244
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	154,676	
			154,676
27	OTHER		
	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	(3,611)
NET FOOD	<u>278,473</u>
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>

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
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	TOTAL Ownership			1,661,237	1,661,237		1,661,237	(205,188)	1,456,049			37
	Ancillary Expense											
	E. Special Cost Centers											
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	TOTAL Special Cost Centers		274,187	288,236	562,423		562,423		562,423			44
45	GRAND TOTAL COST (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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(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	SUBTOTAL (A): (Sum of lines 1-29)	\$ (490,156)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(63,437)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (63,437)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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
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	(19,096)		49

STATE OF ILLINOIS

Summary A

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

	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	TOTAL General Services	(3,611)	0	8,670	7,509	778	0	0	0	0	0	0	13,346	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	(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	TOTAL General Administration	(152,337)	(612,662)	149,457	213,160	40,631	0	0	0	0	0	0	(361,751)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(155,948)	(612,662)	158,127	220,669	41,409	0	0	0	0	0	0	(348,405)	29

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(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	TOTAL Ownership	(334,208)	104,959	24,061	0	0	0	0	0	0	0	0	(205,188)	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)	(490,156)	(507,703)	182,188	220,669	41,409	0	0	0	0	0	0	(553,593)	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		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.

X YES NO

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

1		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.

☒ X

 YES

☐ NO

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

1		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	15
16	V	17	ADMIN COMP - M MAUER		"		22,575	22,575	16
17	V	17	ADMIN COMP - M AARON		"		25,748	25,748	17
18	V	17	ADMIN COMP - F AARON		"				18
19	V	17	ADMIN COMP - D AARON		"				19
20	V	17	ADMIN COMP - S GOLDSTEIN		"		68,563	68,563	20
21	V	17	ADMIN COMP - B FREIDMAN		"				21
22	V	17	ADMIN COMP - R AARON		"				22
23	V	17	ADMIN COMP - S HARAMARAS		"				23
24	V	17	ADMIN COMP - D KUFTA		"		18,989	18,989	24
25	V	17	ADMIN COMP - HOWARD ALTER		"				25
26	V	17	ADMIN COMP - NON OWNER - V DAVIS		"		15,015	15,015	26
27	V	17	ADMIN COMP - NON OWNER - CASSATA		"				27
28	V	17	ADMIN COMP - NON OWNER - VAR		"		23,837	23,837	28
29	V	17	ADMIN COMP - NON OWNER - CFO		"		27,690	27,690	29
30	V	21	CLERICAL COMP - S AARON		"		10,037	10,037	30
31	V	21	CLERICAL COMP - E MARYLES		"		706	706	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 220,669	\$ * 220,669	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.

☒ X

 YES

☐ NO

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

1		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 & 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 & 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:

01/01/2016Ending: 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:

01/01/2016Ending: 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	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 - VA	WGHTD AVG HOURS	45	8	185,179	185,179	6	23,837	14
15	17	ADMIN COMP - NON OWNER - CF	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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D NEHMER	WGHTD AVG HOURS	40	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	CAMBRIDGE		X	MORTGAGE	\$82,849.05	11/2/2010	\$ 16,102,900	\$ 15,586,243	10/1/2052	5.4500	\$ 703,381	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	MB FINANCIAL		X	WORKING CAPITAL				998,782			41,967	6	
7	RELATED PARTY	X		WORKING CAPITAL							43,875	7	
8												8	
9	TOTAL Facility Related				\$82,849.05		\$ 16,102,900	\$ 16,585,025			\$ 789,223	9	
	B. Non-Facility Related*												
10	IRS,IDR,ETC		X	LATE FEES								10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 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.	\$	169,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	175,323	2
3. Under or (over) accrual (line 2 minus line 1).	\$	6,323	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	179,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 200 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.	\$	185,323	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2011	37,736	8
	2012	83,592	9
	2013	124,901	10
	2014	165,335	11
	2015	175,323	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 2015 TAX BILL.			

FOR BHF USE ONLY

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

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) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 22-13-111-001	NURSING HOME	\$ 175,322.80	\$ 175,322.80
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 175,322.80	\$ 175,322.80

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 providecopies of their original second installment tax bill.

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	NURSING HOME	254,390	1998	\$ 1,806,939	1
2					2
3	TOTALS	254,390		\$ 1,806,939	3

Facility Name & ID Number OTTAWA PAVILION

0039230

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	17		1998		\$ 550,000	\$	39	\$ 14,106	\$ 14,106	\$ 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
	Improvement Type**										
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

Facility Name & ID Number OTTAWA PAVILION

0039230

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									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	RELATED PARTY	1,549,644	306,223	30,487	(275,736)	10		74
75	TOTALS	\$ 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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	756,378
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	464,664
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(291,714)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,222,267

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

Facility Name & ID Number OTTAWA PAVILION

0039230

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

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	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17		2014 CHEVY CRUZE	\$ 248.00	\$ 2,975	17
18			704.00	8,448	18
19					19
20					20
21	TOTAL		\$ 952.00	\$ 11,423	21

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 \$ _____

*** 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.**

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				237,081		237,081	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): MED SUPPLIES, LAB, ETC						37,106		37,106	13
14	TOTAL			\$		\$	\$ 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*	
	A. Current Assets			
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 122,000)	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	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,028,214	\$ 3,061,462	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,806,939	13
14	Buildings, at Historical Cost		15,864,469	14
15	Leasehold Improvements, at Historical Cost	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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 209,494	\$ 16,486,554	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,237,708	\$ 19,548,016	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
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
	Other Current Liabilities(specify):			
36	<u>MORTGAGE PREMIUM NET</u>		1,182,121	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,054,082	\$ 3,653,252	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,406,853	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 15,406,853	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,054,082	\$ 19,060,105	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,183,626	\$ 487,911	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,237,708	\$ 19,548,016	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,853,810	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(13,598)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,840,212	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	893,414	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	(550,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 343,414	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,183,626	24 *

* This must agree with page 17, line 47.

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

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,328,166	31
32	Health Care	4,162,261	32
33	General Administration	2,175,109	33
	B. Capital Expense		
34	Ownership	1,661,237	34
	C. Ancillary Expense		
35	Special Cost Centers	274,187	35
36	Provider Participation Fee	288,236	36
	D. Other Expenses (specify):		
37	<u>PRIOR PERIOD EXPENSE</u>	135,620	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,024,816	40
41	Income before Income Taxes (line 30 minus line 40)**	893,414	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 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) <u>HOSPICE/INSURANCE/ETC</u>	98,581	47
48	Other-(specify) <u>VETERAN</u>	193,678	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 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.

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

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

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

** See instructions.

Facility Name & ID Number		OTTAWA PAVILION		STATE OF ILLINOIS		# 0039230		Report Period Beginning:		01/01/2016		Page 21		Ending: 12/31/2016			
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions									
Name		Function		Ownership %		Amount		Description		Amount		Description		Amount			
MARGIE LYLE		ADMINISTRATOR				\$ 38,183		Workers' Compensation Insurance		\$ 109,749		IDPH License Fee		\$ 1,990			
CHRIS RAYBURN		ADMINISTRATOR				31,731		Unemployment Compensation Insurance		69,717		Advertising: Employee Recruitment		59,253			
JON RAGSDALE		ADMINISTRATOR				28,500		FICA Taxes		368,865		Health Care Worker Background Check		3,352			
								Employee Health Insurance		93,588		(Indicate # of checks performed)					
								Employee Meals		0		Patient Background Checks		1,670			
								Illinois Municipal Retirement Fund (IMRF)*				TRUST/FRANCHISE/CONTRIB/ETC		0			
								EMPLOYEE BENEFITS - OTHER		15,179		MARKETING/ADV/PROMO		63,405			
												LICENSES/DUES/SUBSCRIPTIONS		29,132			
TOTAL (agree to Schedule V, line 17, col. 1)						\$ 98,414						MGMT CO ALLOC		1,845			
(List each licensed administrator separately.)												TRUST/FRANCHISE/CONTRIB/ETC		0			
B. Administrative - Other												Less: Public Relations Expense (0)					
Description						Amount						Non-allowable advertising		(63,405)			
MANAGEMENT FEES						\$ 19,991						Yellow page advertising		(0)			
								TOTAL (agree to Schedule V, line 22, col.8)		\$ 657,098				TOTAL (agree to Sch. V, line 20, col. 8) \$ 97,242			
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 19,991				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
(Attach a copy of any management service agreement)																	
C. Professional Services																	
Vendor/Payee		Type				Amount		Description		Line #		Amount		Description		Amount	
						\$						\$		Out-of-State Travel		\$	
SEE SCHEDULE ATTACHED						126,575								In-State Travel			
																0	
														MGMT CO ALLOC		2,126	
														Seminar Expense			
																0	
TOTAL (agree to Schedule V, line 19, column 3)						\$ 126,575		TOTAL		\$				Entertainment Expense ()			
(For legal fee disclosure, see page 39 of instructions)														(agree to Sch. V, line 24, col. 8)		\$ 2,126	
								* Attach copy of IMRF notifications				**See instructions.					

**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>

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 benefit 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

HFS 3745 (N-4-99)

IL478-2471