

Facility Name & ID Number OTTAWA PAVILION

0039230 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	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	119	Skilled (SNF)	119	43,435	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	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			7,205	7,205	8
9	SNF/PED					9
10	ICF	20,125	8,078	171	28,374	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,125	8,078	7,376	35,579	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.91%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 12/1/93

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 24 and days of care provided 7,205

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **OTTAWA PAVILION** # **0039230** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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	199,903	20,251	7,622	227,776		227,776		227,776		1
2	Food Purchase		152,972		152,972		152,972	(1,241)	151,731		2
3	Housekeeping	134,793	25,204		159,997		159,997		159,997		3
4	Laundry	44,830	15,318	1,514	61,662		61,662		61,662		4
5	Heat and Other Utilities			151,569	151,569		151,569	887	152,456		5
6	Maintenance	74,618	28,092	11,533	114,243		114,243	13,038	127,281		6
7	Other (specify):*			8,879	8,879		8,879	592	9,471		7
8	TOTAL General Services	454,144	241,837	181,117	877,098		877,098	13,276	890,374		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,729,291	85,512	35,763	1,850,566		1,850,566	(460)	1,850,106		10
10a	Therapy	236,523	28		236,551		236,551		236,551		10a
11	Activities	110,813	5,474	2,885	119,172		119,172		119,172		11
12	Social Services	34,462		5,205	39,667		39,667		39,667		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,111,089	91,014	49,853	2,251,956		2,251,956	(460)	2,251,496		16
	C. General Administration										
17	Administrative	66,969		98,348	165,317		165,317	(21,912)	143,405		17
18	Directors Fees										18
19	Professional Services			76,646	76,646		76,646	1,519	78,165		19
20	Dues, Fees, Subscriptions & Promotions			24,326	24,326		24,326	(14,696)	9,630		20
21	Clerical & General Office Expenses	48,515	21,839	323,704	394,058		394,058	(253,579)	140,479		21
22	Employee Benefits & Payroll Taxes			403,813	403,813		403,813		403,813		22
23	Inservice Training & Education			3,163	3,163		3,163		3,163		23
24	Travel and Seminar							242	242		24
25	Other Admin. Staff Transportation			16,500	16,500		16,500	(68)	16,432		25
26	Insurance-Prop.Liab.Malpractice			68,785	68,785		68,785	1,822	70,607		26
27	Other (specify):*							22,721	22,721		27
28	TOTAL General Administration	115,484	21,839	1,015,285	1,152,608		1,152,608	(263,951)	888,657		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,680,717	354,690	1,246,255	4,281,662		4,281,662	(251,135)	4,030,527		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	7,200
	REPAIRS & MAINTENANCE	422
		0
		7,622
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,514
		0
		1,514
5	HEAT & OTHER UTILITIES	
	GAS HEAT	56,943
	ELECTRICITY	66,018
	WATER	23,982
	CABLE TV - LOBBY	4,626
		0
		151,569
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	71
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,754
	ELEVATOR MAINTENANCE & REPAIR	5,377
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,331
	FIRE SERVICE	0
		0
		0
		0
		0
		11,533
7	OTHER	
	SCAVENGER	8,879
	SECURITY SERVICE	0
		0
		0
		8,879
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	31,423
	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	4,340
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		35,763
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,885
		0
		2,885
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	5,205
		0
		5,205
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	98,348
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	5,372
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	71,274
		0
		76,646
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,177
	EMPLOYEE WANT ADS XIX F	2,031
	CONTRIBUTIONS VI 20 XIX F	200
	DUES & SUBSCRIPTIONS XIX F	2,814
	LICENSES & PERMITS XIX F	2,004
	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	2,100
	PATIENT BACKGROUND CHECKS XIX F	0
		24,326
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	183
	EQUIPMENT REPAIR & MAINTENANCE	16,963
	OUTSIDE CLERICAL SERVICES	293,860
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	12,698
	MESSENGER SERVICE	0
		0
		323,704

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	203,016
	UNEMPLOYMENT COMPENSATION XIX D	46,145
	WORKERS COMPENSATION INSURANC XIX D	84,983
	HOSPITALIZATION INSURANCE XIX D	52,160
	EMPLOYEE BENEFITS - OTHER XIX D	17,509
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		403,813
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,163
		3,163
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	16,500
		16,500
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	68,785
		68,785
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,246,255

**OTTAWA PAVILION
SCHEDULES
12/31/2007**

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

TOTAL FOOD PURCHASE	152,972
LESS SALES TAX	<u>(1,241)</u>
NET FOOD	151,731

TOTAL PATIENT CENSUS	35,579
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	106,737

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	106,737
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	106,737

NET FOOD	151,731
DIVIDE TOTAL MEALS/YEAR	<u>106,737</u>

COST PER MEAL	1.42
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number

OTTAWA PAVILION

#0039230

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			30,214	30,214		30,214	89,120	119,334			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93,369	93,369		93,369	150,395	243,764			32
33	Real Estate Taxes			83,885	83,885		83,885	3,136	87,021			33
34	Rent-Facility & Grounds			276,000	276,000		276,000	(276,000)				34
35	Rent-Equipment & Vehicles			5,051	5,051		5,051	6,751	11,802			35
36	Other (specify):*											36
37	TOTAL Ownership			488,519	488,519		488,519	(26,598)	461,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		194,194	10,930	205,124		205,124	(46)	205,078			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		194,194	76,083	270,277		270,277	(46)	270,231			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,680,717	548,884	1,810,857	5,040,458		5,040,458	(277,779)	4,762,679			45

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

Facility Name & ID Number **OTTAWA PAVILION**

0039230

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,057)	30		9
10	Interest and Other Investment Income	(263)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,241)	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		21		18
19	Entertainment		20		19
20	Contributions	(200)	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		27		24
25	Fund Raising, Advertising and Promotional	(15,177)	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	(14,029)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,967)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(229,812)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (229,812)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (277,779)		37

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

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

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

OTTAWA PAVILION

ID# 0039230

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING TRAVEL	\$ (1,359)	25	1
2	LEGAL - COLLECTION FEES	(993)	19	2
3	MARKETING SALARY	(11,677)	21	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	(14,029)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OTTAWA PAVILION

0039230

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(1,241)	0	0	0	0	0	0	0	0	0	0	(1,241)	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	887	0	0	0	0	0	0	0	0	887	5
6	Maintenance	0	0	6,954	6,084	0	0	0	0	0	0	0	13,038	6
7	Other (specify):*	0	0	0	0	592	0	0	0	0	0	0	592	7
8	TOTAL General Services	(1,241)	0	7,841	6,084	592	0	0	0	0	0	0	13,276	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	(460)	0	0	0	0	0	(460)	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	(460)	0	0	0	0	0	(460)	16
	C. General Administration													
17	Administrative	0	(98,348)	0	76,436	0	0	0	0	0	0	0	(21,912)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(993)	0	2,512	0	0	0	0	0	0	0	0	1,519	19
20	Fees, Subscriptions & Promotions	(15,377)	0	681	0	0	0	0	0	0	0	0	(14,696)	20
21	Clerical & General Office Expenses	(11,677)	(293,860)	45,286	6,672	0	0	0	0	0	0	0	(253,579)	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	242	0	0	0	0	0	0	0	0	242	24
25	Other Admin. Staff Transportation	(1,359)	0	1,291	0	0	0	0	0	0	0	0	(68)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,822	0	0	0	0	0	0	0	0	1,822	26
27	Other (specify):*	0	0	9,275	0	13,446	0	0	0	0	0	0	22,721	27
28	TOTAL General Administration	(29,406)	(392,208)	61,109	83,108	13,446	0	0	0	0	0	0	(263,951)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(30,647)	(392,208)	68,950	89,192	14,038	(460)	0	0	0	0	0	(251,135)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OTTAWA PAVILION# 0039230

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(17,057)	103,851	2,326	0	0	0	0	0	0	0	0	89,120	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(263)	147,996	2,662	0	0	0	0	0	0	0	0	150,395	32
33	Real Estate Taxes	0	0	3,136	0	0	0	0	0	0	0	0	3,136	33
34	Rent-Facility & Grounds	0	(276,000)	0	0	0	0	0	0	0	0	0	(276,000)	34
35	Rent-Equipment & Vehicles	0	0	6,751	0	0	0	0	0	0	0	0	6,751	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17,320)	(24,153)	14,875	0	0	0	0	0	0	0	0	(26,598)	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	(46)	0	0	0	0	0	(46)	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	(46)	0	0	0	0	0	(46)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(47,967)	(416,361)	83,825	89,192	14,038	(506)	0	0	0	0	0	(277,779)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>SCHEDULE ATTACHED</u>		<u>SCHEDULE ATTACHED</u>		<u>SCHEDULE ATTACHED</u>		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 <u>MANAGEMENT FEE</u>	\$ 98,348	<u>DYNAMIC HEALTHCARE CONSULTANT</u>	100.00%	\$	\$ (98,348)	1
2	V	21 <u>BOOKKEEPING SERVICES</u>	293,860	" "			(293,860)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 <u>RENT</u>	276,000	<u>OTTAWA PAVILION BUILDING LLC</u>			(276,000)	7
8	V	30 <u>DEPRECIATION</u>		" "		103,851	103,851	8
9	V	32 <u>INTEREST</u>				147,996	147,996	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 668,208			\$ 251,847	\$ * (416,361)	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 HEALTHCARE CONSULTANTS	100.00%	\$ 887	\$ 887	15	
16	V	6 REPAIR & MAINT.		" " "		6,954	6,954	16	
17	V	19 PROFESSIONAL FEES		" " "		2,512	2,512	17	
18	V	20 DUES AND SUBSCRIPTION		" " "		681	681	18	
19	V	21 CLERICAL & GENERAL		" " "		45,286	45,286	19	
20	V	24 SEMINARS AND TRAVEL		" " "		242	242	20	
21	V	25 AUTO EXPENSE		" " "		1,291	1,291	21	
22	V	26 INSURANCE		" " "		1,822	1,822	22	
23	V	27 EMP. BEN. - GEN, ADMIN.		" " "		9,275	9,275	23	
24	V	30 DEPRECIATION		" " "		2,326	2,326	24	
25	V	32 INTEREST		" " "		2,662	2,662	25	
26	V	33 REAL ESTATE TAXES		" " "		3,136	3,136	26	
27	V	35 EQUIPMENT RENTAL		" " "		6,751	6,751	27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$ 83,825	\$ *	83,825	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. CMP. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$ 6,084	\$ 6,084
16	V	10 DON SALARY - NON OWNER		" " "			
17	V	17 ADMIN. CMP. - M. MAUER		" " "		16,511	16,511
18	V	17 ADMIN. CMP. - M. AARON		" " "		18,877	18,877
19	V	17 ADMIN. CMP. - F. AARON		" " "			
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		" " "		4,167	4,167
21	V	17 ADMIN. CMP. - S. KOPLIN		" " "			
22	V	17 ADMIN. CMP. - D. MAGAFAS		" " "		11,074	11,074
23	V	17 ADMIN. CMP. - HOWARD ALTER		" " "			
24	V	17 ADMIN. CMP. - NON-OWNER		" " "		10,261	10,261
25	V	17 ADMIN. CMP. - CFO NON-OWNER		" " "		15,546	15,546
26	V	21 CLERICAL. CMP. - S. AARON		" " "		6,672	6,672
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 89,192	\$ * 89,192

* 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 HEALTHCARE CONSULTANTS	100.00%	\$ 592	\$ 592	15
16	V	10 EMP. BEN. - DON NON OWNER		" " "				16
17	V	27 EMP. BEN. - M. MAUER		" " "		1,204	1,204	17
18	V	27 EMP. BEN. - M. AARON		" " "		1,584	1,584	18
19	V	27 EMP. BEN. - F. AARON		" " "				19
20	V	27 EMP. BEN. - S. GOLDSTEIN		" " "		3,809	3,809	20
21	V	27 EMP. BEN. - S. KOPLIN		" " "				21
22	V	27 EMP. BEN. - D. MAGAFAS		" " "		923	923	22
23	V	27 EMP. BEN. - H. ALTER		" " "				23
24	V	27 EMP. BEN. - NON-OWNER		" " "		2,512	2,512	24
25	V	27 EMP. BEN. - CFO NON-OWNER		" " "		2,010	2,010	25
26	V	27 EMP. BEN. - S. AARON		" " "		1,404	1,404	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 14,038	\$ * 14,038	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	10 MEDICAL SUPPLIES	\$ 15,772	LINCOLN MEDICAL SUPPLIES, INC.		\$ 15,312	\$ (460)
16	V	39 ANCILLARY EXPENSE	1,596	" " "		1,550	(46)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 17,368			\$ 16,862	\$ * (506)

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

Facility Name & ID Number

OTTAWA PAVILION

#

0039230

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	\$ 18,877	17-7	1
2	MARSHALL MAUER		ADMINISTRATIVE					SALARY	16,511	17-7	2
3	SHARON AARON		CLERICAL					SALARY	6,672	21-7	3
4	DENNIS NEHMER		MAINTENANCE					SALARY	6,084	6-7	4
5	DIANA MAGAFAS		ADMINISTRATIVE					SALARY	11,074	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 59,218		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: **01/01/2007**

Ending: **2/31/2007**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W MAIN STREET
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	388,610	11	\$ 9,690	\$ 35,579	\$ 887	1
2	6	REPAIR & MAINT.	" "	388,610	11	75,959	35,579	6,954	2
3	19	PROFESSIONAL FEES	" "	388,610	11	27,437	35,579	2,512	3
4	20	DUES AND SUBSCRIPTION	" "	388,610	11	7,442	35,579	681	4
5	21	CLERICAL & GENERAL	" "	388,610	11	494,636	380,513	45,286	5
6	24	SEMINARS AND TRAVEL	" "	388,610	11	2,640	35,579	242	6
7	25	AUTO EXPENSE	" "	388,610	11	14,104	35,579	1,291	7
8	26	INSURANCE	" "	388,610	11	19,903	35,579	1,822	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	388,610	11	101,305	35,579	9,275	9
10	30	DEPRECIATION	" "	388,610	11	25,409	35,579	2,326	10
11	32	INTEREST	" "	388,610	11	29,080	35,579	2,662	11
12	33	REAL ESTATE TAXES	" "	388,610	11	34,252	35,579	3,136	12
13	35	EQUIPMENT RENTAL	" "	388,610	11	73,733	35,579	6,751	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 915,590	\$ 380,513	\$ 83,825	25

Facility Name & ID Number OTTAWA PAVILION

0039230 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W MAIN STREET
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	11	\$ 58,010	\$ 58,010	4	\$ 6,084	1
2	10	ADMIN. CMP. - DON NON OWNER	"	40	11	73,306	73,306			2
3	17	ADMIN. CMP. - M. MAUER	"	40	11	180,000	180,000	4	16,511	3
4	17	ADMIN. CMP. - M. AARON	"	40	11	180,000	180,000	4	18,877	4
5	17	ADMIN. CMP. - F. AARON	"	45	11	95,250	95,250			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	"	45	11	37,505	37,505	5	4,167	6
7	17	ADMIN. CMP. - S. KOPLIN	"	30	11	71,549	71,549			7
8	17	ADMIN. CMP. - D. MAGAFAS	"	50	11	105,666	105,666	5	11,074	8
9	17	ADMIN. CMP. - H. ALTER	"	40	11	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER	"	45	11	97,823	97,823	5	10,261	10
11	17	ADMIN. CMP. - CFO NON-OWNER	"	45	11	169,480	169,480	4	15,546	11
12	21	CLERICAL. - S. AARON		40	11	72,716	72,716	4	6,672	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,153,305	\$ 1,153,305		\$ 89,192	25

Facility Name & ID Number OTTAWA PAVILION

0039230 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization DYNAMIC HEALTHCARE CONSULTANTS
 Street Address 3359 W MAIN STREET
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	11	\$ 5,643	4	\$ 592	1
2	17	EMP.BEN. - DON NON OWNER	" "	40	11	19,251			2
3	27	EMP.BEN. - M. MAUER	" "	40	11	13,131	4	1,204	3
4	27	EMP. BEN. - M. AARON	" "	40	11	15,105	4	1,584	4
5	27	EMP. BEN. - F. AARON	" "	45	11	43,896			5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	45	11	34,284	5	3,809	6
7	27	EMP. BEN. - S. KOPLIN	" "	30	11	25,887			7
8	27	EMP. BEN. - D. MAGAFAS	" "	50	11	8,807	5	923	8
9	27	EMP. BEN. - H. ALTER	" "	40	11	1,120			9
10	27	EMP. BEN. - NON-OWNER	" "	45	11	23,953	5	2,512	10
11	27	EMP. BEN. - CFO NON-OWNER	" "	45	11	21,910	4	2,010	11
12	27	EMP. BEN. - S. AARON	" "	40	11	15,300	4	1,404	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 228,287	\$	\$ 14,038	25

Facility Name & ID Number OTTAWA PAVILION

0039230 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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 HEALTHCARE 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	LINCOLN MEDICAL SUPPLIES	DIRECT ALLOCATION			\$	\$		\$ 15,312	1
2	10 MEDICAL SUPPLIES							1,550	2
3	39 ANCILLARY EXPENSE								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	TOTALS				\$	\$		\$ 16,862	25

Facility Name & ID Number

OTTAWA PAVILION

0039230

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
A. Directly Facility Related												
Long-Term												
1	CHASE BANK		X	MORTGAGE	7917+INT	11/05	\$ 1,900,000	\$ 1,702,083	11/25	PRIME+	\$ 147,996	1
2												2
3												3
4	RELATED PARTY										2,662	4
5			X	INSURANCE FINANCING							1,708	5
Working Capital												
6	CHASE BANK		X	LINE OF CREDIT	INTEREST	11/07	850,000	315,000	11/08	8.2500	51,839	6
7	MAUER/AARON	X		WORKING CAPITAL				455,500			22,322	7
8	RELATED FACILITIES	X		WORKING CAPITAL				352,020			17,500	8
9	TOTAL Facility Related						\$ 2,750,000	\$ 2,824,603			\$ 244,027	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,750,000	\$ 2,824,603			\$ 244,027	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 2006 report.	\$	39,000	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.)	\$	59,885	2
3. Under or (over) accrual (line 2 minus line 1).	\$	20,885	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	63,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	83,885	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	20,607	8
	2003	50,977	9
	2004	37,869	10
	2005	38,036	11
	2006	59,885	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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 2006 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OTTAWA PAVILION COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0039230

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>22-13-111-001</u>	<u>NURSING HOME</u>	\$ <u>59,884.50</u>	\$ <u>59,884.50</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>59,884.50</u>	\$ <u>59,884.50</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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,128 B. General Construction Type: Exterior Frame Number of Stories 3

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>		<u>1998</u>	<u>\$ 400,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 400,000	3

Facility Name & ID Number OTTAWA PAVILION

0039230

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	119	1998		\$ 1,567,864	\$ 57,013	39	\$ 57,013	\$	\$ 121,153	4
5										5
6										6
7										7
8	RELATED PARTY			40,614	1,042	35	1,160	118	16,632	8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENT		1994	13,015	333	39	333		4,475	9
10	WALLPAPER		1995	18,314	470	39	470		5,753	10
11	DRYWALL IN CORRIDOR		1995	17,550	450	39	450		5,531	11
12	HANDRAILS		1995	7,839	201	39	201		2,454	12
13	SECURITY DOOR		1995	1,602	41	39	41		494	13
14	MIXING VALVE & WATER HEATER		1995	756	19	39	19		229	14
15	HANDRAIL & BUMPER		1996	6,895	177	39	177		2,117	15
16	HANDRAIL & BUMPER		1996	721	18	39	18		210	16
17	ALARM		1996	1,146	29	39	29		331	17
18	PANIC DEVICE		1996	1,550	40	39	40		448	18
19	REPLACE RECONNECT SWITCH & STARTER		1996	1,074	28	39	28		311	19
20	DRAPERIES		1996	13,334	342	39	342		3,776	20
21	DRAPERY, CARPETING		1997	12,786	328	39	328		3,350	21
22	PIPING WORK, HEAT/COOL UNITS		1997	4,341	111	39	111		1,138	22
23	HEAT/COOL UNITS		1998	4,732	121	39	121		1,228	23
24	OFFICE REMODELING		1998	1,475	38	39	38		363	24
25	SHELVING/COOLER		1998	1,493	38	39	38		295	25
26	BOILER, HEAT/COOL UNIT		1999	10,441	268	39	268		2,381	26
27	ALARM SYSTEM		1999	2,853	73	39	73		654	27
28	WINDOWS		1999	19,785	507	39	507		3,901	28
29	FOLDING STEEL GATE		1999	884	23	39	23		185	29
30	REMODELING DISHWASHER ROOM		1999	5,000	128	39	128		1,029	30
31	DRAPERIES		1999	6,439	165	39	165		1,354	31
32	PARKING LOT PAVING		1999	1,834	47	39	47		404	32
33	BASEMENT REMODEL		2000	15,203	553	27.5	553		4,061	33
34	WINDOW REPAIR -- DOOR		2000	3,026	110	27.5	110		807	34
35	FEED PUMP -- HOT WATER VALVE		2000	4,131	150	27.5	150		1,103	35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number OTTAWA PAVILION

0039230

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	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	SPRINKLER SYSTEM REPAIR	2000	\$ 1,175	\$ 43	27.5	\$ 43		\$ 316	37
38	AIR CONDITIONER	2000	1,273	46	27.5	46		338	38
39	CARPETING -- SHEERS	2000	5,693	254	20	285	31	3,246	39
40	BASEMENT REMODEL	2001	20,088	730	27.5	730		4,730	40
41	BOILER/SPRINKLER REPAIRS	2001	10,031	365	27.5	365		2,363	41
42	BOILER REPAIR/PUMP/COMPRESSOR	2002	11,888	432	27.5	432		2,311	42
43	HEATER	2002	2,938	107	27.5	107		551	43
44	BASEMENT REMODEL	2002	18,705	680	27.5	680		3,717	44
45	BOILER REPAIR/PUMPS/CONDENSING UNIT	2003	9,701	353	27.5	353		1,574	45
46	SPRINKLER SYSTEM REPAIR	2003	16,320	593	27.5	593		3,644	46
47	DOOR CAMERAS AND LOCKS	2003	4,591	167	27.5	167		744	47
48	AIR CONDITIONER 5 TON	2003	1,960	71	27.5	71		314	48
49	SERVICE SINK	2003	802	29	27.5	29		129	49
50	WALL REPAIR - WATER DAMAGE	2003	1,370	50	27.5	50		223	50
51	PAINTING	2004	17,082	621	27.5	621		2,148	51
52	BOILER,CONDENSATE DRUMS & COMPRESSOR	2004	3,277	119	27.5	119		412	52
53	STAINLESS STEEL TOPS FOR TABLES	2004	1,065	39	27.5	39		134	53
54	EXHAUST DUCTS/HOOD & A/C COMPRESSOR	2005	2,789	101	27.5	101		249	54
55	ROOF	2005	30,875	1,123	27.5	1,123		2,761	55
56	FIRE PANEL FOR ALARM SYSTEM	2005	7,757	282	27.5	282		693	56
57	WATER TREATMENT, CONDENSER PUMP	2005	10,107	368	27.5	368		904	57
58	SPRINKLER HEADS	2006	1,862	68	27.5	68		99	58
59	CUBICLE CURTAINS	2006	1,267	46	27.5	46		67	59
60	AIR CONDITIONER	2006	1,349	49	27.5	49		72	60
61	PIPING & RELIEF VALVE FOR BOILER	2006	3,548	129	27.5	129		188	61
62	SUMP PUMP	2007	3,128	52	27.5	52		52	62
63	HEAT & AC UNITS	2007	1,804	30	27.5	30		30	63
64	FLAT RUBBER ROOF	2007	2,685	45	27.5	45		45	64
65	BOILER REPAIR	2007	2,301	38	27.5	38		38	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,984,128	\$ 69,893		\$ 70,042	\$ 149	\$ 218,259	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 202,017	\$ 12,797	\$ 18,937	\$ 6,140	10 YRS	\$ 123,264	71
72	Current Year Purchases	23,983	4,797	1,199	(3,598)	10 YRS	1,199	72
73	Fully Depreciated Assets	44,055					44,055	73
74	RELATED PARTY	269,271	47,144	25,878	(21,266)		84,252	74
75	TOTALS	\$ 539,326	\$ 64,738	\$ 46,014	\$ (18,724)		\$ 252,770	75

D. Vehicle Depreciation (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	FACILITY	1999 DODGE RAM VAN	2002	\$ 13,563	\$ 781	\$ 1,151	\$ 370		\$ 11,797	76
77	RELATED PARTY			15,787	979	2,127	1,148		10,471	77
78										78
79										79
80	TOTALS			\$ 29,350	\$ 1,760	\$ 3,278	\$ 1,518		\$ 22,268	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)	\$ 2,952,804	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 136,391	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,334	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (17,057)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 493,297	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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: \$ 5,051 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

* 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>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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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 prescripts				191,105		191,105	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MED SUPPLIES, LAB,RADIOLOGY Other (specify):					10,930	3,089		14,019	13
14	TOTAL			\$		\$ 10,930	\$ 194,194		\$ 205,124	14

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

Facility Name & ID Number OTTAWA PAVILION
 XV. BALANCE SHEET - Unrestricted Operating Fund.

0039230
 As of 12/31/2007

Report Period Beginning: 01/01/2007
 (last day of reporting year)

Ending: 12/31/2007

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 80,186	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 150,000)	872,672		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,300		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	158,306		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,161,464	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	375,651		15
16	Equipment, at Historical Cost	283,619		16
17	Accumulated Depreciation (book methods)	(333,004)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSIT	360		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 326,626	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,488,090	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 581,389	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	315,000		29
30	Accrued Salaries Payable	213,913		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,814		31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,000		32
33	Accrued Interest Payable	1,458		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,191,574	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	421,300		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 421,300	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,612,874	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (124,784)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,488,090	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (382,741)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (382,741)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	257,957	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 257,957	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)	\$ (124,784)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,140,147	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,140,147	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	158,005	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 158,005	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		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	263	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 263	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,298,415	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	877,098	31
32	Health Care	2,251,956	32
33	General Administration	1,152,608	33
	B. Capital Expense		
34	Ownership	488,519	34
	C. Ancillary Expense		
35	Special Cost Centers	205,124	35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,040,458	40
41	Income before Income Taxes (line 30 minus line 40)**	257,957	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 257,957	43

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

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

TAX RETURN PREPARED ON CASH BASIS

*** 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:

01/01/2007

Ending:

12/31/2007

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	1,908	2,052	\$ 61,089	\$ 29.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,599	12,393	298,546	24.09	3
4	Licensed Practical Nurses	17,984	19,128	410,680	21.47	4
5	CNAs & Orderlies	75,235	80,222	921,455	11.49	5
6	CNA Trainees					6
7	Licensed Therapist	8,066	8,881	236,523	26.63	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,965	2,206	28,233	12.80	9
10	Activity Assistants	9,043	9,651	82,580	8.56	10
11	Social Service Workers	1,752	1,969	34,462	17.50	11
12	Dietician					12
13	Food Service Supervisor	1,965	2,217	36,375	16.41	13
14	Head Cook	1,906	2,056	20,066	9.76	14
15	Cook Helpers/Assistants	14,958	16,115	143,462	8.90	15
16	Dishwashers					16
17	Maintenance Workers	5,805	6,309	74,618	11.83	17
18	Housekeepers	14,302	15,690	134,793	8.59	18
19	Laundry	5,080	5,495	44,830	8.16	19
20	Administrator	1,837	2,201	66,969	30.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,082	3,443	48,515	14.09	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	3,242	3,510	37,521	10.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,729	193,538	\$ 2,680,717 *	\$ 13.85	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	\$ 7,200	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	4,340	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,885	11-3	44
45	Social Service Consultant	E	5,205	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,630		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	60	\$ 3,546	10-3	50
51	Licensed Practical Nurses	653	27,877	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	713	\$ 31,423		53

Facility Name & ID Number OTTAWA PAVILION

0039230

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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? NO
If YES, give association name and amount. _____
- (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. \$ 11,404 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 _____ 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. \$ 65,153
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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees