



Facility Name & ID Number OTTAWA PAVILION

# 0039230 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**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	10,560	5,142	5,795	21,497	8
9	SNF/PED					9
10	ICF	10,939	1,342	48	12,329	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,499	6,484	5,843	33,826	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.88%**

**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 119 and days of care provided 5,795

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name &amp; ID Number

OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	214,742	26,879	8,278	249,899		249,899		249,899		1
2	Food Purchase		182,911		182,911		182,911	(864)	182,047		2
3	Housekeeping	133,976	23,612		157,588		157,588		157,588		3
4	Laundry	60,852	11,263	3,895	76,010		76,010		76,010		4
5	Heat and Other Utilities			148,334	148,334		148,334	1,145	149,479		5
6	Maintenance	87,825	41,535	17,778	147,138		147,138	11,990	159,128		6
7	Other (specify):*			5,844	5,844		5,844	605	6,449		7
8	<b>TOTAL General Services</b>	497,395	286,200	184,129	967,724		967,724	12,876	980,600		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,840,183	55,851	13,811	1,909,845		1,909,845	(225)	1,909,620		10
10a	Therapy	332,251	725		332,976		332,976		332,976		10a
11	Activities	127,197	6,239	2,705	136,141		136,141		136,141		11
12	Social Services	28,698		1,733	30,431		30,431		30,431		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,328,329	62,815	24,249	2,415,393		2,415,393	(225)	2,415,168		16
	<b>C. General Administration</b>										
17	Administrative	71,211		77,966	149,177		149,177	47,356	196,533		17
18	Directors Fees										18
19	Professional Services			48,889	48,889		48,889	(1,867)	47,022		19
20	Dues, Fees, Subscriptions & Promotions			35,430	35,430		35,430	(21,659)	13,771		20
21	Clerical & General Office Expenses	70,424	20,353	321,595	412,372		412,372	(262,543)	149,829		21
22	Employee Benefits & Payroll Taxes			418,264	418,264		418,264		418,264		22
23	Inservice Training & Education			2,455	2,455		2,455		2,455		23
24	Travel and Seminar							499	499		24
25	Other Admin. Staff Transportation			13,561	13,561		13,561	(359)	13,202		25
26	Insurance-Prop.Liab.Malpractice			59,366	59,366		59,366	1,316	60,682		26
27	Other (specify):*			56,168	56,168		56,168	(19,813)	36,355		27
28	<b>TOTAL General Administration</b>	141,635	20,353	1,033,694	1,195,682		1,195,682	(257,070)	938,612		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,967,359	369,368	1,242,072	4,578,799		4,578,799	(244,419)	4,334,380		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	8,278
	REPAIRS & MAINTENANCE	0
		0
		8,278
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	3,895
		0
		3,895
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	56,043
	ELECTRICITY	71,208
	WATER	15,429
	CABLE TV - LOBBY	5,654
		0
		148,334
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	755
	PAINTING & DECORATING	1,703
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,544
	ELEVATOR MAINTENANCE & REPAIR	9,196
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,580
	FIRE SERVICE	0
		0
		0
		0
		0
		17,778
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	5,844
	SECURITY SERVICE	0
		0
		0
		5,844
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	9,061
	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	4,750
	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
		13,811
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	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
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,705
		0
		2,705
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,733
		0
		1,733
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	77,966
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	8,988
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	39,901
		0
		48,889
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	21,905
	EMPLOYEE WANT ADS XIX F	3,936
	CONTRIBUTIONS VI 20 XIX F	200
	DUES & SUBSCRIPTIONS XIX F	3,588
	LICENSES & PERMITS XIX F	3,201
	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	1,150
	PATIENT BACKGROUND CHECKS XIX F	1,450
		35,430
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,777
	EQUIPMENT REPAIR & MAINTENANCE	16,485
	OUTSIDE CLERICAL SERVICES	290,160
	PENALTIES / OVERDRAFT CHARGES VI 18	2,210
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	9,963
	MESSENGER SERVICE	0
		0
		321,595

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	224,216
	UNEMPLOYMENT COMPENSATION XIX D	24,998
	WORKERS COMPENSATION INSURANCE XIX D	97,022
	HOSPITALIZATION INSURANCE XIX D	60,725
	EMPLOYEE BENEFITS - OTHER XIX D	11,303
	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
		418,264
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	2,455
		2,455
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	13,561
		13,561
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	59,366
		59,366
27	<b>OTHER</b>	
	BAD DEBTS VI 24	56,168
		56,168

GRAND TOTAL COLUMN 3 OTHER

1,242,072

**OTTAWA PAVILION  
SCHEDULES  
12/31/2009**

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

TOTAL FOOD PURCHASE	182,911
LESS SALES TAX	<u>(864)</u>
NET FOOD	182,047
TOTAL PATIENT CENSUS	33,826
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	101,478
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	101,478
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	101,478
NET FOOD	182,047
DIVIDE TOTAL MEALS/YEAR	<u>101,478</u>
COST PER MEAL	1.79
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>
	=====

Facility Name &amp; ID Number

OTTAWA PAVILION

#0039230

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			38,568	38,568		38,568	86,906	125,474			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,801	69,801		69,801	46,706	116,507			32
33	Real Estate Taxes			65,997	65,997		65,997	3,438	69,435			33
34	Rent-Facility & Grounds			276,000	276,000		276,000	(276,000)				34
35	Rent-Equipment & Vehicles			7,005	7,005		7,005	6,407	13,412			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			457,371	457,371		457,371	(132,543)	324,828			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		160,246	79,177	239,423		239,423	(218)	239,205			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	<b>TOTAL Special Cost Centers</b>		160,246	144,330	304,576		304,576	(218)	304,358			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,967,359	529,614	1,843,773	5,340,746		5,340,746	(377,180)	4,963,566			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.)

Table with columns: NON-ALLOWABLE EXPENSES, Amount, Reference, BHF USE ONLY. Rows 1-30 including Day Care, Governmental Sponsored Special Programs, Non-Patient Meals, etc.

BHF USE ONLY table with columns 48-52

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

Table with columns: Amount, Reference. Rows 31-37 including Non-Paid Workers-Attach Schedule\*, Donated Goods-Attach Schedule\*, Amortization of Organization & Pre-Operating Expense, etc.

\*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.)

Table with columns: Yes, No, Amount, Reference. Rows 38-47 including Medically Necessary Transport., Gift and Coffee Shops, Barber and Beauty Shops, etc.

OTTAWA PAVILION

ID# 0039230

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount Reference

	Amount	Reference	Sch. V Line
1	MARKETING SALARIES	\$ -25136	21
2	MARKETING TRAVEL	(828)	25
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	<b>Total</b>	(25,964)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number OTTAWA PAVILION# 0039230

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(864)	0	0	0	0	0	0	0	0	0	0	(864)	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	1,145	0	0	0	0	0	0	0	0	1,145	5
6	Maintenance	0	0	5,835	6,155	0	0	0	0	0	0	0	11,990	6
7	Other (specify):*	0	0	0	0	605	0	0	0	0	0	0	605	7
8	<b>TOTAL General Services</b>	<b>(864)</b>	<b>0</b>	<b>6,980</b>	<b>6,155</b>	<b>605</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>12,876</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(225)	0	0	0	0	0	(225)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(225)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(225)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(77,966)	0	125,322	0	0	0	0	0	0	0	47,356	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,701)	0	834	0	0	0	0	0	0	0	0	(1,867)	19
20	Fees, Subscriptions & Promotions	(22,105)	0	446	0	0	0	0	0	0	0	0	(21,659)	20
21	Clerical & General Office Expenses	(27,346)	(290,160)	47,368	7,595	0	0	0	0	0	0	0	(262,543)	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	499	0	0	0	0	0	0	0	0	499	24
25	Other Admin. Staff Transportation	(828)	0	469	0	0	0	0	0	0	0	0	(359)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,316	0	0	0	0	0	0	0	0	1,316	26
27	Other (specify):*	(56,168)	0	9,198	0	27,157	0	0	0	0	0	0	(19,813)	27
28	<b>TOTAL General Administration</b>	<b>(109,148)</b>	<b>(368,126)</b>	<b>60,130</b>	<b>132,917</b>	<b>27,157</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(257,070)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(110,012)</b>	<b>(368,126)</b>	<b>67,110</b>	<b>139,072</b>	<b>27,762</b>	<b>(225)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(244,419)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number OTTAWA PAVILION# 0039230

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	2,846	80,908	3,152	0	0	0	0	0	0	0	0	86,906	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,048)	53,917	2,837	0	0	0	0	0	0	0	0	46,706	32
33	Real Estate Taxes	0	0	3,438	0	0	0	0	0	0	0	0	3,438	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	6,407	0	0	0	0	0	0	0	0	6,407	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(7,202)</b>	<b>(141,175)</b>	<b>15,834</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(132,543)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(218)	0	0	0	0	0	(218)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(218)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(218)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(117,214)</b>	<b>(509,301)</b>	<b>82,944</b>	<b>139,072</b>	<b>27,762</b>	<b>(443)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(377,180)</b>	<b>45</b>

Facility Name & ID Number **OTTAWA PAVILION**

# **0039230**

Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

**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
<b>SCHEDULED ATTACHED</b>		<b>SCHEDULE ATTACHED</b>		<b>SCHEDULE ATTACHED</b>		

**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	\$ 77,966	DYNAMIC HEALTH CARE CONSULTANTS		\$ (77,966)	1
2	V	21	BOOKKEEPING SERVICES	290,160	" "		(290,160)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34	RENT	276,000	800 E. CENTER ST		(276,000)	7
8	V	30	DEPRECIATION		" "	80,908	80,908	8
9	V	32	INTEREST		" "	53,917	53,917	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 644,126			\$ 134,825	\$ * (509,301)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization			6	7		8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization			Percent of Ownership	Operating Cost of Related Organization		Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	DYNAMIC HEALTH CARE CONSULTANTS			100.00%	\$ 1,145	\$ 1,145	15	
16	V	6	REPAIR & MAINT.		"	"	"		5,835	5,835	16	
17	V	19	PROFESSIONAL FEES		"	"	"		834	834	17	
18	V	20	DUES AND SUBSCRIPTION		"	"	"		446	446	18	
19	V	21	CLERICAL & GENERAL		"	"	"		47,368	47,368	19	
20	V	24	SEMINARS AND TRAVEL		"	"	"		499	499	20	
21	V	25	AUTO EXPENSE		"	"	"		469	469	21	
22	V	26	INSURANCE		"	"	"		1,316	1,316	22	
23	V	27	EMP. BEN. - GEN, ADMIN.		"	"	"		9,198	9,198	23	
24	V	30	DEPRECIATION		"	"	"		3,152	3,152	24	
25	V	32	INTEREST		"	"	"		2,837	2,837	25	
26	V	33	REAL ESTATE TAXES		"	"	"		3,438	3,438	26	
27	V	35	EQUIPMENT RENTAL		"	"	"		6,407	6,407	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			\$					\$ 82,944	\$ *	82,944	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 MAINT COMP - D NEHMER	\$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	\$ 6,155	\$ 6,155
16	V	17 ADMIN COMP - M MAUER		" " "		16,791	16,791
17	V	17 ADMIN COMP - M AARON		" " "		19,041	19,041
18	V	17 ADMIN COMP - F AARON		" " "			
19	V	17 ADMIN COMP - S GOLDSTEIN		" " "		35,453	35,453
20	V	17 ADMIN COMP - J AARON		" " "			
21	V	17 ADMIN COMP - S KOPLIN		" " "			
22	V	17 ADMIN COMP - D MAGAFAS		" " "		15,658	15,658
23	V	17 ADMIN COMP - HOWARD ALTER		" " "			
24	V	17 ADMIN COMP - NON OWNER - V DAVIS		" " "			
25	V	17 ADMIN COMP - NON OWNER - VAR		" " "		21,111	21,111
26	V	17 ADMIN COMP - NON OWNER - CFO		" " "		17,268	17,268
27	V	21 CLERICAL COMP - S AARON		" " "		7,595	7,595
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 139,072	\$ * 139,072

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization			6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization			Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	7	EMP BEN - D NEHMER	\$	DYNAMIC HEALTH CARE CONSULTANTS			100.00%	\$ 605	\$ 605	15	
16	V	27	EMP BEN - M MAUER		"	"	"		1,205	1,205	16	
17	V	27	EMP BEN - M AARON		"	"	"		1,572	1,572	17	
18	V	27	EMP BEN - F AARON		"	"	"				18	
19	V	27	EMP BEN - S GOLDSTEIN		"	"	"		14,148	14,148	19	
20	V	27	EMP BEN - J AARON		"	"	"				20	
21	V	27	EMP BEN - S KOPLIN		"	"	"				21	
22	V	27	EMP BEN - D MAGAFAS		"	"	"		1,014	1,014	22	
23	V	27	EMP BEN - HOWARD ALTER		"	"	"				23	
24	V	27	EMP BEN - V DAVIS		"	"	"				24	
25	V	27	EMP BEN - NON OWNER		"	"	"		5,957	5,957	25	
26	V	27	EMP BEN - NON OWNER - CFO		"	"	"		1,910	1,910	26	
27	V	27	EMP BEN - S AARON		"	"	"		1,351	1,351	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			\$					\$ 27,762	\$ *	27,762	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	\$ 2,085	LINCOLN MEDICAL SUPPLIES	100.00%	\$ 1,860	\$	(225)	15
16	V	39	ANCILLARY EXPENSE	2,021	" " "		1,803		(218)	16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									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			\$ 4,106			\$ 3,663	\$ *	(443)	39

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

Facility Name &amp; ID Number

OTTAWA PAVILION

#

0039230

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	\$ 19,041	17-7	1
2	MARSHALL MAUER		ADMINISTRATIVE					SALARY	16,791	17-7	2
3	SHARON AARON		CLERICAL					SALARY	7,595	21-7	3
4	DENNIS NEHMER		MAINTENANCE					SALARY	6,155	6-7	4
5	DIANA MAGAFAS		ADMINISTRATIVE					SALARY	15,658	17-7	5
6	S GOLDSTEIN		ADMINISTRATIVE					SALARY	35,453	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 100,693		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:

01/01/2009

Ending: 2/31/2009

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 ST  
 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	TOTAL PATIENT DAYS	393,498	11	\$ 13,322	\$	33,826	\$ 1,145	1
2	6	REPAIR & MAINT.	TOTAL PATIENT DAYS	393,498	11	67,883		33,826	5,835	2
3	19	PROFESSIONAL FEES	TOTAL PATIENT DAYS	393,498	11	9,699		33,826	834	3
4	20	DUES AND SUBSCRIPTION	TOTAL PATIENT DAYS	393,498	11	5,183		33,826	446	4
5	21	CLERICAL & GENERAL	TOTAL PATIENT DAYS	393,498	11	551,031	404,350	33,826	47,368	5
6	24	SEMINARS AND TRAVEL	TOTAL PATIENT DAYS	393,498	11	5,810		33,826	499	6
7	25	AUTO EXPENSE	TOTAL PATIENT DAYS	393,498	11	5,452		33,826	469	7
8	26	INSURANCE	TOTAL PATIENT DAYS	393,498	11	15,305		33,826	1,316	8
9	27	EMP. BEN. - GEN, ADMIN.	TOTAL PATIENT DAYS	393,498	11	107,005		33,826	9,198	9
10	30	DEPRECIATION	TOTAL PATIENT DAYS	393,498	11	36,672		33,826	3,152	10
11	32	INTEREST	TOTAL PATIENT DAYS	393,498	11	33,003		33,826	2,837	11
12	33	REAL ESTATE TAXES	TOTAL PATIENT DAYS	393,498	11	39,991		33,826	3,438	12
13	35	EQUIPMENT RENTAL	TOTAL PATIENT DAYS	393,498	11	74,530		33,826	6,407	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					\$ 964,886	\$ 404,350		\$ 82,944	25

Facility Name & ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 ST  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847 ) 679-8219  
 Fax Number ( 847 ) 679-7377

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	8	\$ 63,031	\$ 63,031	4	\$ 6,155	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	10	195,000	195,000	3	16,791	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	8	195,000	195,000	4	19,041	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	106,000	106,000			4
5	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	94,542	94,542	15	35,453	5
6	17	ADMIN COMP - J AARON	WGHTD AVG HOURS	40	1	2,657	2,657			6
7	17	ADMIN COMP - S KOPLIN	WGHTD AVG HOURS	30	3	73,196	73,196			7
8	17	ADMIN COMP - D MAGAFAS	WGHTD AVG HOURS	50	8	160,425	160,425	5	15,658	8
9	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			9
10	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	1	74,152	74,152			10
11	17	ADMIN COMP - NON OWNER - VA	WGHTD AVG HOURS	45	8	216,303	216,303	4	21,111	11
12	17	ADMIN COMP - NON OWNER - CI	WGHTD AVG HOURS	45	10	200,543	200,543	4	17,268	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	10	88,338	88,338	3	7,595	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					\$ 1,481,187	\$ 1,481,187		\$ 139,072	25

Facility Name & ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 ST  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847 ) 679-8219  
 Fax Number ( 847 ) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D NEHMER	WGHTD AVG HOURS	40	8	\$ 6,197	\$ 4	\$ 605	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	10	13,995	3	1,205	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	8	16,097	4	1,572	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	43,678			4
5	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	37,728	15	14,148	5
6	27	EMP BEN - J AARON	WGHTD AVG HOURS	40	1				6
7	27	EMP BEN - S KOPLIN	WGHTD AVG HOURS	30	3	25,540			7
8	27	EMP BEN - D MAGAFAS	WGHTD AVG HOURS	50	8	10,394	5	1,014	8
9	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,079			9
10	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	1	17,756			10
11	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	8	61,038	4	5,957	11
12	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	45	10	22,185	4	1,910	12
13	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	10	15,719	3	1,351	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					\$ 271,406	\$	\$ 27,762	25

Facility Name & ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 LINCOLN MEDICAL SUPPLIES  
 Street Address 3359 W MAIN ST  
 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	10	MEDICAL SUPPLIES	DIRECT ALLOCATION		\$	\$		\$ 1,860	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION					1,803	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	TOTALS				\$	\$		\$ 3,663	25

Facility Name &amp; ID Number

OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1	CHASE BANK		X	MORTGAGE	7917+INT	11/05	\$ 1,900,000	\$ 1,499,278	11/25	PRIME +	\$ 53,917	1							
2												2							
3												3							
4			X	INSURANCE FINANCING							989	4							
5	RELATED PARTY	X									2,837	5							
	<b>Working Capital</b>																		
6	MB FINANCIAL		X	WORKING CAPITAL				593,822			23,348	6							
7	M MAUER/M AARON	X		WORKING CAPITAL				421,300			14,422	7							
8	WOODBIDGE/STERLING	X		WORKING CAPITAL				575,000			31,042	8							
9	TOTAL Facility Related						\$ 1,900,000	\$ 3,089,400			\$ 126,555	9							
	<b>B. Non-Facility Related*</b>																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 1,900,000	\$ 3,089,400			\$ 126,555	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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>60,000</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>61,997</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>1,997</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>64,000</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>65,997</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>37,869</b>	<b>8</b>
	2005	<b>38,036</b>	<b>9</b>
	2006	<b>59,885</b>	<b>10</b>
	2007	<b>59,153</b>	<b>11</b>
	2008	<b>61,997</b>	<b>12</b>

**2009 REAL ESTATE TAX ACCRUAL IS BASED ON 103% OF THE 2008 REAL ESTATE TAX BILL**

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
14	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
15	LESS REFUND FROM LINE 6	\$	<b>15</b>
16	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

**2008 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 2008 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 2008.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>22-13-111-001</u>	<u>NURSING HOME</u>	\$ <u>61,997.26</u>	\$ <u>61,997.26</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>61,997.26</u>	\$ <u>61,997.26</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

**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.

Facility Name & ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		1998	\$ 314,027	1
2					2
3	TOTALS			\$ 314,027	3

Facility Name &amp; ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

**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	\$	\$ 235,179	4
5											5
6											6
7											7
8	RELATED PARTY				38,133	977	35	1,090	113	17,795	8
	<b>Improvement Type**</b>										
9	LEASEHOLD IMPROVEMENT		1994		13,015	333	39	333		5,141	9
10	WALLPAPER		1995		18,314	470	39	470		6,693	10
11	DRYWALL IN CORRIDOR		1995		17,550	450	39	450		6,431	11
12	HANDRAILS		1995		7,839	201	39	201		2,856	12
13	SECURITY DOOR		1995		1,602	41	39	41		576	13
14	MIXING VALVE & WATER HEATER		1995		756	19	39	19		267	14
15	HANDRAIL & BUMPER		1996		6,895	177	39	177		2,471	15
16	HANDRAIL & BUMPER		1996		721	18	39	18		346	16
17	ALARM		1996		1,146	29	39	29		389	17
18	PANIC DEVICE		1996		1,550	40	39	40		528	18
19	REPLACE RECONNECT SWITCH & STARTER		1996		1,074	28	39	28		367	19
20	DRAPERIES		1996		13,334	342	39	342		4,460	20
21	DRAPERY, CARPETING		1997		12,786	328	39	328		4,006	21
22	PIPING WORK, HEAT/COOL UNITS		1997		4,341	111	39	111		1,360	22
23	HEAT/COOL UNITS		1998		4,732	121	39	121		1,470	23
24	OFFICE REMODELING		1998		1,475	38	39	38		439	24
25	SHELVING/COOLER		1998		1,493	38	39	38		371	25
26	BOILER, HEAT/COOL UNIT		1999		10,441	268	39	268		2,917	26
27	ALARM SYSTEM		1999		2,853	73	39	73		800	27
28	WINDOWS		1999		19,785	507	39	507		4,915	28
29	FOLDING STEEL GATE		1999		884	23	39	23		231	29
30	REMODELING DISHWASHER ROOM		1999		5,000	128	39	128		1,285	30
31	DRAPERIES		1999		6,439	165	39	165		1,684	31
32	PARKING LOT PAVING		1999		1,834	47	39	47		498	32
33	BASEMENT REMODEL		2000		15,203	553	27.5	553		5,167	33
34	WINDOW REPAIR -- DOOR		2000		3,026	110	27.5	110		1,027	34
35	FEED PUMP -- HOT WATER VALVE		2000		4,131	150	27.5	150		1,403	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 &amp; ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	SPRINKLER SYSTEM REPAIR	2000	\$ 1,175	\$ 43	27.5	\$ 43	\$	\$ 402	37
38	AIR CONDITIONER	2000	1,273	46	27.5	46		430	38
39	CARPETING -- SHEERS	2000	5,693		20	285	285	3,816	39
40	BASEMENT REMODEL	2001	20,088	730	27.5	730		6,190	40
41	BOILER/SPRINKLER REPAIRS	2001	10,031	365	27.5	365		3,093	41
42	BOILER REPAIR/PUMP/COMPRESSOR	2002	11,888	432	27.5	432		3,175	42
43	HEATER	2002	2,938	107	27.5	107		765	43
44	BASEMENT REMODEL	2002	18,705	680	27.5	680		5,077	44
45	BOILER REPAIR/PUMPS/CONDENSING UNIT	2003	9,701	353	27.5	353		2,280	45
46	SPRINKLER SYSTEM REPAIR	2003	16,320	593	27.5	593		4,830	46
47	DOOR CAMERAS AND LOCKS	2003	4,591	167	27.5	167		1,078	47
48	AIR CONDITIONER 5 TON	2003	1,960	71	27.5	71		456	48
49	SERVICE SINK	2003	802	29	27.5	29		187	49
50	WALL REPAIR - WATER DAMAGE	2003	1,370	50	27.5	50		323	50
51	PAINTING	2004	17,082	621	27.5	621		3,390	51
52	BOILER,CONDENSATE DRUMS & COMPRESSOR	2004	3,277	119	27.5	119		650	52
53	STAINLESS STEEL TOPS FOR TABLES	2004	1,065	39	27.5	39		212	53
54	EXHAUST DUCTS/HOOD & A/C COMPRESSOR	2005	2,789	101	27.5	101		451	54
55	ROOF	2005	30,875	1,123	27.5	1,123		5,007	55
56	FIRE PANEL FOR ALARM SYSTEM	2005	7,757	282	27.5	282		1,257	56
57	WATER TREATMENT, CONDENSER PUMP	2005	10,107	368	27.5	368		1,640	57
58	SPRINKLER HEADS	2006	1,862	68	27.5	68		235	58
59	CUBICLE CURTAINS	2006	1,267	46	27.5	46		159	59
60	AIR CONDITIONER	2006	1,349	49	27.5	49		170	60
61	PIPING & RELIEF VALVE FOR BOILER	2006	3,548	129	27.5	129		446	61
62	SUMP PUMP	2007	3,128	114	27.5	114		280	62
63	HEAT & AC UNITS	2007	1,804	65	27.5	65		160	63
64	FLAT RUBBER ROOF	2007	2,685	98	27.5	98		241	64
65	BOILER REPAIR	2007	2,301	84	27.5	84		206	65
66	WATER TREATMENT, CONDENSER PUMP	2008	9,909	360	27.5	360		525	66
67	GENERATOR, COMPRESSOR,BOILER	2008	12,431	452	27.5	452		659	67
68	DOORS, LIGHTS	2008	15,993	582	27.5	582		849	68
69	DINING ROOM REMODEL	2008	25,855	940	27.5	940		1,271	69
70	TOTAL (lines 4 thru 69)		\$ 2,045,835	\$ 72,104		\$ 72,502	\$ 398	\$ 360,982	70

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

Facility Name & ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,045,835	\$ 72,104		\$ 72,502	\$ 398	\$ 360,982	1
2	2008	3,100	113	27.5	113		165	2
3	2009	2,263	38	27.5	38		38	3
4	2009	4,059	68	27.5	68		68	4
5	2009	4,476	75	27.5	75		75	5
6	2009	5,548	92	27.5	92		92	6
7	2009	1,347	22	27.5	22		22	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		\$ 2,066,628	\$ 72,512		\$ 72,910	\$ 398	\$ 361,442	34

\*\*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:

01/01/2009

Ending:

12/31/2009

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	\$ 244,470	\$ 17,850	\$ 22,047	\$ 4,197	10 YRS	\$ 126,015	71
72	Current Year Purchases	10,943	6,196	547	(5,649)	10 YRS	547	72
73	Fully Depreciated Assets	86,812					86,812	73
74	RELATED PARTY	257,612	23,895	26,606	2,711		195,857	74
75	TOTALS	\$ 599,837	\$ 47,941	\$ 49,200	\$ 1,259		\$ 409,231	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	RELATED PARTY			\$ 17,020	\$ 2,175	\$ 2,785	\$ 610		\$ 3,559	76
77	FACILITY	1999 DODGE RAM VAN	2002	13,563		579	579		13,563	77
78										78
79										79
80	TOTALS			\$ 30,583	\$ 2,175	\$ 3,364	\$ 1,189		\$ 17,122	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)	\$ 3,011,075	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 122,628	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,474	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,846	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 787,795	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: NA

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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: \$ 7,005 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	<b>TOTAL</b>		\$	\$	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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 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			71,584			71,584	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				158,103		158,103	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>SUPPLIES, LAB, XRAY</u>					7,593	2,143		9,736	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$ 79,177	\$ 160,246		\$ 239,423	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 &amp; ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning: 01/01/2009

Ending:

12/31/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 65,000 )	957,292		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,762		6
7	Other Prepaid Expenses	3,989		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,030,043	\$	10
	<b>B. Long-Term Assets</b>			
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	460,631		15
16	Equipment, at Historical Cost	355,788		16
17	Accumulated Depreciation (book methods)	(435,372)		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): SECURITY DEPOSIT	153,860		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 534,907	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,564,950	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 738,465	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	593,822		29
30	Accrued Salaries Payable	148,705		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,299		31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,000		32
33	Accrued Interest Payable	4,008		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,556,299	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	421,300		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 421,300	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,977,599	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (412,649)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,564,950	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(536,785)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(536,785)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(175,864)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>ADDITIONAL CAPITAL</b>	<b>300,000</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>124,136</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(412,649)</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,083,231	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,083,231	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	419,712	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 419,712	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	10,048	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 10,048	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,512,991	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	967,724	31
32	Health Care	2,415,393	32
33	General Administration	1,195,682	33
<b>B. Capital Expense</b>			
34	Ownership	457,371	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	239,423	35
36	Provider Participation Fee	65,153	36
<b>D. Other Expenses (specify):</b>			
37	<b>OUT-OF-PERIOD EXPENSES</b>	348,109	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,688,855	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(175,864)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (175,864)	43

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

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

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

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

Facility Name & ID Number OTTAWA PAVILION

# 0039230

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	1,893	2,121	\$ 64,683	\$ 30.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,234	12,749	339,886	26.66	3
4	Licensed Practical Nurses	18,297	19,789	444,822	22.48	4
5	CNAs & Orderlies	70,847	75,766	925,683	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,436	10,455	332,251	31.78	8
9	Activity Director	2,053	2,453	33,465	13.64	9
10	Activity Assistants	8,324	8,833	93,732	10.61	10
11	Social Service Workers	1,694	1,744	28,698	16.46	11
12	Dietician					12
13	Food Service Supervisor	2,005	2,276	39,081	17.17	13
14	Head Cook	1,330	1,396	12,843	9.20	14
15	Cook Helpers/Assistants	15,499	16,443	162,818	9.90	15
16	Dishwashers					16
17	Maintenance Workers	5,769	6,139	87,825	14.31	17
18	Housekeepers	13,269	14,245	133,976	9.41	18
19	Laundry	5,842	6,372	60,852	9.55	19
20	Administrator	1,946	2,233	71,211	31.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,059	5,613	70,424	12.55	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	4,043	4,438	65,109	14.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,540	193,065	\$ 2,967,359 *	\$ 15.37	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	163	\$ 8,278	1-3	35
36	Medical Director		6,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		4,750	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	61	2,705	11-3	44
45	Social Service Consultant		1,733	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	224	\$ 23,466		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	40	\$ 1,857	10-3	50
51	Licensed Practical Nurses	164	7,204	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	204	\$ 9,061		53



Facility Name & ID Number OTTAWA PAVILION

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. \$ 12,945 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. \$ 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: \_\_\_\_\_
- (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.