

		FOR BHF USE					

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH Facility ID Number:** 0032029

**Facility Name:** Hickory Nursing Pavilion

**Address:** 9246 South Roberts Road Hickory Hills 60457  
 Number City Zip Code

**County:** Cook

**Telephone Number:** (708) 598-4040 **Fax #** (708) 598-3796

**HFS ID Number:** 363499382001

**Date of Initial License for Current Owners:** 03/01/87

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Steve Lavenda **Telephone Number:** (847) 236 - 1111

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

MAIL TO: BUREAU OF HEALTH FINANCE  
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	<u>34</u>	Skilled (SNF)	<u>34</u>	<u>12,410</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>40</u>	Intermediate (ICF)	<u>40</u>	<u>14,600</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,010</u>	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	<u>3,613</u>		<u>1,117</u>	<u>4,730</u>	8
9	SNF/PED					9
10	ICF	<u>15,634</u>	<u>357</u>		<u>15,991</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,247</u>	<u>357</u>	<u>1,117</u>	<u>20,721</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.72%

D. How many bed-hold days during this year were paid by the Department? 34 (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 03/01/87

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

YES  Date 03/01/87 NO

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

YES  NO  If YES, enter number of beds certified 34 and days of care provided 1,117

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/05 Ending: 12/31/05

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	111,930	21,558	5,904	139,392		139,392		139,392		1
2	Food Purchase		94,507		94,507	(63,948)	30,559	(16)	30,543		2
3	Housekeeping	72,768	25,901		98,669		98,669		98,669		3
4	Laundry	33,798	8,881		42,679		42,679		42,679		4
5	Heat and Other Utilities			57,367	57,367		57,367	820	58,187		5
6	Maintenance	27,062	6,820	30,012	63,894		63,894	4,397	68,291		6
7	Other (specify):*							377	377		7
8	<b>TOTAL General Services</b>	245,558	157,667	93,283	496,508	(63,948)	432,560	5,578	438,138		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,000	8,000		8,000		8,000		9
10	Nursing and Medical Records	706,493	28,748	20,678	755,919		755,919		755,919		10
10a	Therapy	23,526		860	24,386		24,386		24,386		10a
11	Activities	50,908	953	846	52,707		52,707		52,707		11
12	Social Services	31,960		1,689	33,649		33,649		33,649		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	812,887	29,701	32,073	874,661		874,661		874,661		16
	<b>C. General Administration</b>										
17	Administrative	62,013		146,400	208,413		208,413	(71,270)	137,143		17
18	Directors Fees										18
19	Professional Services			35,256	35,256	(6,388)	28,868	227	29,095		19
20	Dues, Fees, Subscriptions & Promotions			30,473	30,473		30,473	(14,192)	16,281		20
21	Clerical & General Office Expenses	27,668	26,014	29,947	83,629		83,629	852	84,481		21
22	Employee Benefits & Payroll Taxes			188,156	188,156	63,948	252,104		252,104		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,695	1,695		1,695	244	1,939		24
25	Other Admin. Staff Transportation			1,462	1,462		1,462	853	2,315		25
26	Insurance-Prop.Liab.Malpractice			68,761	68,761		68,761	1,007	69,768		26
27	Other (specify):*							15,198	15,198		27
28	<b>TOTAL General Administration</b>	89,681	26,014	502,150	617,845	57,560	675,405	(67,081)	608,324		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,148,126	213,382	627,506	1,989,014	(6,388)	1,982,626	(61,503)	1,921,123		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hickory Nursing Pavilion #0032029 Report Period Beginning: 01/01/05 Ending: 12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			19,853	19,853		19,853	87,559	107,412			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,607	1,607		1,607	29,274	30,881			32
33	Real Estate Taxes			118,030	118,030	6,388	124,418	3,359	127,777			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)	(0)			34
35	Rent-Equipment & Vehicles							2,782	2,782			35
36	Other (specify):*							1,275	1,275			36
37	<b>TOTAL Ownership</b>			319,490	319,490	6,388	325,878	(55,751)	270,127			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		27,506	61,336	88,842		88,842		88,842			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		27,506	101,851	129,357		129,357		129,357			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,148,126	240,888	1,048,847	2,437,861		2,437,861	(117,255)	2,320,606			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/05

Ending: 12/31/05

**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	OHF 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	50,245	30		9
10	Interest and Other Investment Income	(2,476)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(16)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,385)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,861)	21		24
25	Fund Raising, Advertising and Promotional	(4,991)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(14,285)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 10,231		\$	30

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

		1	2	
		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)	(127,485)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (127,485)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (117,255)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

OHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Reference
1 Marketing Expense	\$ (8,259)	20
2 Replacement Income Tax	(3,862)	21
3 Unallowable Legal Fee	(750)	19
4 C/PEL Dues	(1,051)	20
5 Reimbd Co. Replacement Tax	(863)	21
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101 Total	(14,286)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning:

01/01/05

Ending:

12/31/05

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													1
2	Food Purchase	(16)											(16)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			820									820	5
6	Maintenance			1,363	3,034								4,397	6
7	Other (specify):*				377								377	7
8	<b>TOTAL General Services</b>	<b>(16)</b>		<b>2,183</b>	<b>3,411</b>								<b>5,578</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(134,731)	63,461								(71,270)	17
18	Directors Fees													18
19	Professional Services	(750)		821		156							227	19
20	Fees, Subscriptions & Promotions	(14,301)		109									(14,192)	20
21	Clerical & General Office Expenses	(22,471)	363	22,943		17							852	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			244									244	24
25	Other Admin. Staff Transportation			853									853	25
26	Insurance-Prop.Liab.Malpractice			762		245							1,007	26
27	Other (specify):*			11,067	4,131								15,198	27
28	<b>TOTAL General Administration</b>	<b>(37,522)</b>	<b>363</b>	<b>(97,932)</b>	<b>67,592</b>	<b>418</b>							<b>(67,081)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(37,538)</b>	<b>363</b>	<b>(95,749)</b>	<b>71,003</b>	<b>418</b>							<b>(61,503)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning:

01/01/05 Ending:

Summary B

12/31/05

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	50,245	35,397			1,917							87,559	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,476)	28,754	156		2,840							29,274	32
33	Real Estate Taxes					3,359							3,359	33
34	Rent-Facility & Grounds		(180,000)	8,303		(8,303)							(180,000)	34
35	Rent-Equipment & Vehicles			2,782									2,782	35
36	Other (specify):*		1,275										1,275	36
37	<b>TOTAL Ownership</b>	<b>47,769</b>	<b>(114,574)</b>	<b>11,241</b>		<b>(187)</b>							<b>(55,751)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>10,231</b>	<b>(114,211)</b>	<b>(84,508)</b>	<b>71,003</b>	<b>231</b>							<b>(117,255)</b>	<b>45</b>

**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
See Attached		See Attached		See Attached		

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	34 Rent Income	\$ 180,000	Hickory Healthcare Association	100.00%	\$	\$ (180,000)	1
2	V	32 Interest Income	528	Hickory Healthcare Association	100.00%		(528)	2
3	V	33 Accounting Fees		Hickory Healthcare Association	100.00%			3
4	V	32 Mortgage Interest		Hickory Healthcare Association	100.00%	29,282	29,282	4
5	V	30 Depreciation		Hickory Healthcare Association	100.00%	35,397	35,397	5
6	V	36 Amortization		Hickory Healthcare Association	100.00%	1,275	1,275	6
7	V	21 Replacement Tax		Hickory Healthcare Association	100.00%	363	363	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 180,528			\$ 66,317	\$ * (114,211)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion# 0032029Report Period Beginning: 01/01/05Ending: 12/31/05

## 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	\$	STAYCARE MANAGEMENT, LTD.	100.00%	\$ 820	\$ 820	15
16	V	6 REPAIRS AND MAINT.				1,363	1,363	16
17	V	17 ADMIN. SAL.-NON OWNER				11,669	11,669	17
18	V	19 PROFESSIONAL FEES				821	821	18
19	V	20 DUES, SUBSCRIPTIONS				109	109	19
20	V	21 CLERICAL & GENERAL				22,943	22,943	20
21	V	24 SEMINARS				244	244	21
22	V	25 ADMIN. STAFF TRAVEL				853	853	22
23	V	26 INSURANCE				762	762	23
24	V	27 EMPLOYEE BENEFITS				11,067	11,067	24
25	V	32 INTEREST				156	156	25
26	V	34 BUILDING RENT				8,303	8,303	26
27	V	35 EQUIPMENT RENTAL				2,782	2,782	27
28	V							28
29	V	17 MANAGEMENT FEE	146,400				(146,400)	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		\$ 146,400			\$ 61,892	\$ * (84,508)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	1	DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$ 0	\$	15
16	V	6	MAINT. COMP. - NON-OWNER				3,034	3,034	16
17	V	7	EMP. BEN. - S. WEBSTER				0		17
18	V	7	EMP. BEN. - MAINT. NON-OWNER				377	377	18
19	V	17	ADMIN. COMP - H. WENGROW				50,769	50,769	19
20	V	17	ADMIN. COMP - J. WEBSTER				12,692	12,692	20
21	V	27	EMP. BEN. - H. WENGROW				3,312	3,312	21
22	V	27	EMP. BEN. - J. WEBSTER				819	819	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		\$				\$ 71,003	\$ * 71,003	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	19 PROFESSIONAL FEES	\$	DOUBLE YOU REALTY, LLC	100.00%	\$ 156	\$ 156	15
16	V	21 OFFICE EXPENSE		DOUBLE YOU REALTY, LLC		17	17	16
17	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		245	245	17
18	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		1,917	1,917	18
19	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		2,840	2,840	19
20	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		3,359	3,359	20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	8,303	DOUBLE YOU REALTY, LLC			(8,303)	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		\$ 8,303			\$ 8,534	\$ * 231	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			\$			\$		15
16	V								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			\$			\$ 0	\$ *	39

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

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/05

Ending: 12/31/05

**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			\$			\$		15
16	V								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			\$			\$ 0	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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			\$			\$		15
16	V								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			\$			\$ 0	\$ *	39

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

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/05

Ending: 12/31/05

**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			\$			\$		15
16	V								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			\$			\$ 0	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/05

Ending: 12/31/05

**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			\$			\$		15
16	V								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			\$			\$ 0	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/05

Ending: 12/31/05

**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			\$			\$		15
16	V								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			\$			\$ 0	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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	Jeff Webster	Owner	Administration	14.19%	See Attached	5.00	7.69%	Salary-Staycar	\$ 12,692	17-7	1
2	Howard Wengrow	Owner	Administration	14.19%	See Attached	20.00	30.77%	Salary-Staycare	50,769	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 63,461		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 STAYCARE MANAGEMENT, LTD.  
 Street Address 3737 W ARTHUR AVENUE  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number (847) 679-2121  
 Fax Number (847) 679-2122

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	179,651	5	\$ 7,111	\$ 20,718	\$ 820	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	179,651	5	11,821	20,718	1,363	2	
3	17	ADMIN. SAL.-NON OWNER	PATIENT DAYS	179,651	5	101,183	101,183	20,718	11,669	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	179,651	5	7,117	20,718	821	4	
5	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	179,651	5	949	20,718	109	5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	179,651	5	198,942	169,197	20,718	22,943	6
7	24	SEMINARS	PATIENT DAYS	179,651	5	2,115	20,718	244	7	
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	179,651	5	7,399	20,718	853	8	
9	26	INSURANCE	PATIENT DAYS	179,651	5	6,610	20,718	762	9	
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	179,651	5	95,966	20,718	11,067	10	
11	32	INTEREST	PATIENT DAYS	179,651	5	1,350	20,718	156	11	
12	34	BUILDING RENT	PATIENT DAYS	179,651	5	72,000	20,718	8,303	12	
13	35	EQUIPMENT RENTAL	PATIENT DAYS	179,651	5	24,120	20,718	2,782	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					\$ 536,683	\$ 270,380	\$ 61,892	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 STAYCARE MANAGEMENT, LTD.  
 Street Address 3737 W ARTHUR AVENUE  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number (847) 679-2121  
 Fax Number (847) 679-2122

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	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	35	1	10,604	10,604		1
2	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	5	26,310	26,310	5	3,034
3	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	35	1	1,445			3
4	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	5	3,267		5	377
5	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	5	165,000	165,000	20	50,769
6	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	65	5	165,000	165,000	5	12,692
7	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	5	10,765		20	3,312
8	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	65	5	10,641		5	819
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					\$ 393,032	\$ 366,914		\$ 71,003

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 DOUBLE YOU REALTY, LLC  
 Street Address 3737 W. ARTHUR AVENUE  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number (847) 679-2121  
 Fax Number (847) 679-2122

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	19	PROFESSIONAL FEES	PATIENT DAYS	179,651	5	\$ 1,350	\$ 20,718	\$ 156	1
2	21	OFFICE EXPENSE	PATIENT DAYS	179,651	5	150	20,718	17	2
3	26	INSURANCE	PATIENT DAYS	179,651	5	2,123	20,718	245	3
4	30	DEPRECIATION	PATIENT DAYS	179,651	5	16,627	20,718	1,917	4
5	32	INTEREST EXPENSE	PATIENT DAYS	179,651	5	24,628	20,718	2,840	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	179,651	5	29,131	20,718	3,359	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					\$ 74,009	\$	\$ 8,534	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Alloc. From Hickory HC Associates	X	Mortgage MB Financial			\$	411,233			\$ 29,282	1									
2											2									
3	Alloc. From Double You	X	Mortgage MB Financial							2,840	3									
4											4									
5	See Supplemental Schedule										5									
<b>Working Capital</b>																				
6	Due on Insurance	X	Insurance				59,667			1,607	6									
7	Alloc. From Stay Care	X								156	7									
8	See Supplemental Schedule										8									
9	<b>TOTAL Facility Related</b>					\$	470,900			\$ 33,885	9									
<b>B. Non-Facility Related*</b>																				
10											10									
11											11									
12											12									
13	See Supplemental Schedule									(3,004)	13									
14	<b>TOTAL Non-Facility Related</b>					\$				\$ (3,004)	14									
15	<b>TOTALS (line 9+line14)</b>					\$	470,900			\$ 30,881	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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 - SUPPLEMENTAL SCHEDULE**

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	<b>TOTAL Long-Term</b>											7								
	<b>Working Capital</b>																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Working Capital</b>											14								
	<b>B. Non-Facility Related*</b>																			
15	<u>Interest Income</u>						\$	\$			\$	<u>(2,476)</u>	15							
16	<u>Interest Income Bldg. Co.</u>											<u>(528)</u>	16							
17												17								
18												18								
19												19								
20	<b>TOTAL Non-Facility Related</b>											<b><u>(3,004)</u></b>	20							

\* 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

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ <u>94,705</u>	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.)		\$ <u>108,155</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>13,450</u>	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <u>107,940</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$ <u>6,388</u>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ <u>10,837</u> For <u>2002</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <u>127,778</u>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	<u>92,790</u>	8
	2001	<u>94,953</u>	9
	2002	<u>89,440</u>	10
	2003	<u>91,947</u>	11
	2004	<u>104,796</u>	12
<u>2005 Accrual \$104,796 x 1.03 = \$107,940</u>			
<u>Alloc From Double You = \$3,359</u>			
<b>FOR OHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2004 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 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.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Hickory Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032029

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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>23-02-420-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>2,970.68</u>	\$ <u>2,970.68</u>
2. <u>23-02-420-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>44,064.04</u>	\$ <u>44,064.04</u>
3. <u>23-02-420-015-0000</u>	<u>Long Term Care Property</u>	\$ <u>5,551.34</u>	\$ <u>5,551.34</u>
4. <u>23-02-420-016-0000</u>	<u>Long Term Care Property</u>	\$ <u>44,042.42</u>	\$ <u>44,042.42</u>
5. <u>23-01-302-021-0000</u>	<u>Long Term Care Property</u>	\$ <u>8,167.28</u>	\$ <u>8,167.28</u>
6. _____	<u>Alloc. From Double You</u>	\$ <u>29,131.00</u>	\$ <u>3,359.00</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>133,926.76</u>	\$ <u>108,154.76</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? X YES 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 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.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Hickory Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032029

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ _____	\$ _____

**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        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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029 Report Period Beginning:

01/01/05 Ending:

12/31/05

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 16,200 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

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).

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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	Facility	16,200	1990	\$ 74,000	1
2	Alloc from Double You		2003	5,766	2
3	TOTALS	16,200		\$ 79,766	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Various			1987	22,801		20	1,140	1,140	17,854	9
10	Various			1988	50,319		20	2,516	2,516	38,182	10
11	Various			1989	7,409		20	370	370	5,141	11
12	Various			1990	38,661		20	1,934	1,934	27,172	12
13	Various			1991	6,422		20	321	321	4,233	13
14	Various			1993	30,582		20	1,530	1,530	17,809	14
15	Various			1994	13,592		20	680	680	7,503	15
16	Various			1995	102,781		20	5,139	5,139	52,509	16
17	Various			1996	139,610		20	6,980	6,980	67,445	17
18	Various			1997	54,749		20	2,739	2,739	23,267	18
19	Various			1998	53,522		20	2,676	2,676	20,539	19
20	Various			1999	18,879		20	944	944	6,080	20
21	Various			2000	6,891		20	345	345	1,723	21
22	Various			2001	12,916		20	646	646	2,886	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

**See Page 12A, Line 70 for total**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		1,115,000	35,397		55,750	20,353	738,920	67
68		57,670	1,413		1,541	128	4,507	68
69			19,853			(19,853)		69
70		\$ 1,731,804	\$ 56,663		\$ 85,251	\$ 28,588	\$ 1,035,770	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,731,804	\$ 56,663		\$ 85,251	\$ 28,588	\$ 1,035,770	1
2	Wiring Outlets	2002	14,779		20	1,478	1,478	5,912	2
3	Drywall-Office	2002	2,650		20	265	265	972	3
4	Call Cord	2002	564		20	56	56	183	4
5	Motor	2002	1,854		20	185	185	726	5
6	Relay Switch	2002	537		20	54	54	192	6
7	Coupler	2002	754		20	75	75	245	7
8	Heater	2002	3,539		20	354	354	1,209	8
9	Tuckpointing	2003	3,800		20	380	380	950	9
10	Outside Fence	2003	2,230		20	112	112	316	10
11	Outside Fence	2003	600		20	30	30	78	11
12	Outside Fence	2003	1,200		20	60	60	150	12
13	Electrical Repair	2003	735		20	37	37	86	13
14	Fire Rated Door	2003	655		20	33	33	74	14
15	Fire Rated Door	2003	533		20	27	27	60	15
16	Outside Fence	2003	730		20	37	37	82	16
17	Outside Fence	2003	900		20	45	45	101	17
18	Signage	2003	2,012		20	101	101	226	18
19	Flooring	2003	699		20	35	35	76	19
20	Nurses Station Remodeling	2003	8,482		20	424	424	919	20
21	Telephone Installation	2003	515		20	26	26	56	21
22	Wallcovering	2003	1,001		20	50	50	108	22
23	Wall Covering, Paint, Flooring	2003	43,996		20	2,200	2,200	4,950	23
24	Motor	2004	818		20	41	41	44	24
25	Fire Door Frame	2004	758		20	38	38	41	25
26	Door	2004	1,156		20	58	58	111	26
27	Thermostat And Temp Sensor	2004	628		20	31	31	44	27
28	Doorframes	2005	2,800		20	257	257	257	28
29	Phone System	2005	4,178		20	209	209	209	29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,834,907	\$ 56,663		\$ 91,949	\$ 35,286	\$ 1,054,147	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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		
1	<b>Totals from Page 12B, Carried Forward</b>	\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>		1
2									2
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4									4
5									5
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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		
1	<b>Totals from Page 12C, Carried Forward</b>		\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>	1
2									2
3									3
4									4
5									5
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30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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		
1	<b>Totals from Page 12D, Carried Forward</b>	\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>		1
2									2
3									3
4									4
5									5
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31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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		
1	<b>Totals from Page 12E, Carried Forward</b>	\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>		1
2									2
3									3
4									4
5									5
6									6
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27									27
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30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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		
1	<b>Totals from Page 12F, Carried Forward</b>	\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>		1
2									2
3									3
4									4
5									5
6									6
7									7
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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		
1	<b>Totals from Page 12G, Carried Forward</b>		\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>	1
2									2
3									3
4									4
5									5
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28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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		
1	<b>Totals from Page 12H, Carried Forward</b>		\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
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12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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	
1	<b>Totals from Page 12I, Carried Forward</b>		\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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		
1	<b>Totals from Page 12J, Carried Forward</b>	\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>		1
2									2
3									3
4									4
5									5
6									6
7									7
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ <b>1,834,907</b>	\$ <b>56,663</b>		\$ <b>91,949</b>	\$ <b>35,286</b>	\$ <b>1,054,147</b>		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1990	1961	\$ 1,115,000	\$ 35,397		\$ 55,750	\$ 20,353	\$ 738,920	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
			<b>1,115,000</b>		<b>55,750</b>	<b>20,353</b>	<b>738,920</b>	
			<b>35,397</b>					

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

**01/01/05**

Ending:

**12/31/05**

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated From Double You		2003	2003	\$ 55,117	\$ 1,413		\$ 1,413	\$	\$ 4,181	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Allocated From Staycare			2003	2,553	-		128	128	326	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Hickory Nursing Pavilion**

# **0032029**

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
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61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
			57,670		1,413	1,541	128	4,507

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	\$ 133,924	\$ 504	\$ 14,817	\$ 14,313	10	\$ 79,249	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	103,471				10	103,471	73
74								74
75	TOTALS	\$ 237,395	\$ 504	\$ 14,817	\$ 14,313		\$ 182,720	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		Allocation from Stay Care	2003	\$ 3,229	\$	\$ 646	\$ 646	5	\$ 1,614	76
77										77
78										78
79										79
80	TOTALS			\$ 3,229	\$	\$ 646	\$ 646		\$ 1,614	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)		\$ 2,155,297	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 57,167	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 107,412	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 50,245	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,238,481	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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

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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

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 N/A.

9. Option to Buy:  YES  NO Terms: N/A \*

**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: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Alloc from Stay Care</u>		\$	\$ <u>2,782</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>2,782</u>	21

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

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

**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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		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)	
<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.
- SEE ACCOUNTANTS' COMPILATION REPORT

## 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 - 03	hrs	\$		\$ 27,318	\$		\$ 27,318	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			269			269	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			33,599			33,599	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				27,506		27,506	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					150			150	13
14	<b>TOTAL</b>			\$		\$ 61,336	\$ 27,506		\$ 88,842	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion# 0032029Report Period Beginning: 01/01/05

Ending:

12/31/05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(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	\$ 236,508	\$ 284,373	1
2	Cash-Patient Deposits	29,422	29,422	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	686,041	686,041	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,778	69,778	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		14,039	8
9	Other(specify): <u>See Attached Schedule</u>	35	35	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,021,784	\$ 1,083,688	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		74,000	13
14	Buildings, at Historical Cost		1,115,000	14
15	Leasehold Improvements, at Historical Cost	484,049	484,049	15
16	Equipment, at Historical Cost	201,354	312,354	16
17	Accumulated Depreciation (book methods)	(355,121)	(1,001,511)	17
18	Deferred Charges		12,745	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(8,925)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 330,282	\$ 987,712	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,352,066	\$ 2,071,400	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 46,123	\$ 46,123	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,422	29,422	28
29	Short-Term Notes Payable	59,667	59,667	29
30	Accrued Salaries Payable	34,184	34,184	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	107,940	107,940	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	238,727	27,049	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 516,063	\$ 304,385	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		411,233	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 411,233	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 516,063	\$ 715,618	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 836,003	\$ 1,355,782	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,352,066	\$ 2,071,400	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>716,807</b>	<b>1</b>
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>716,807</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	<b>119,196</b>	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>119,196</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>836,003</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/05

Ending: 12/31/05

**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	\$ 2,505,831	1
2	Discounts and Allowances for all Levels	(139,022)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,366,809</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	119,214	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 119,214</b>	<b>8</b>
<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	47,243	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,618	19
20	Radiology and X-Ray	506	20
21	Other Medical Services	6,354	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 57,721</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,476	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 2,476</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	10,837	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 10,837</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,557,057</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	496,508	31
32	Health Care	874,661	32
33	General Administration	617,845	33
<b>B. Capital Expense</b>			
34	Ownership	319,490	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	88,842	35
36	Provider Participation Fee	40,515	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,437,861</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>119,196</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 119,196</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/05

Ending:

12/31/05

**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	2,014	1,912	\$ 74,024	\$ 38.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,277	4,520	168,898	37.37	3
4	Licensed Practical Nurses	9,209	10,164	209,886	20.65	4
5	CNAs & Orderlies	28,876	31,469	237,060	7.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,924	2,174	23,526	10.82	8
9	Activity Director	1,913	2,061	22,797	11.06	9
10	Activity Assistants	3,452	3,723	28,111	7.55	10
11	Social Service Workers	2,131	2,291	31,960	13.95	11
12	Dietician					12
13	Food Service Supervisor	1,818	2,064	29,429	14.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,920	9,787	82,501	8.43	15
16	Dishwashers					16
17	Maintenance Workers	2,069	2,343	27,062	11.55	17
18	Housekeepers	9,107	9,715	72,768	7.49	18
19	Laundry	3,755	4,209	33,798	8.03	19
20	Administrator	1,994	2,103	62,013	29.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,349	1,566	27,668	17.67	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	640	709	16,625	23.45	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	83,448	90,810	\$ 1,148,126 *	\$ 12.64	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	Monthly	\$ 5,904	01-03	35
36	Medical Director	Monthly	8,000	09-03	36
37	Medical Records Consultant	Monthly	6,240	10-03	37
38	Nurse Consultant	6	200	10-03	38
39	Pharmacist Consultant	Monthly	1,190	10-03	39
40	Physical Therapy Consultant	9	360	10a-03	40
41	Occupational Therapy Consultant	10	430	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	70	10a-03	43
44	Activity Consultant	17	846	11-03	44
45	Social Service Consultant	32	1,689	12-03	45
46	Other(specify)				46
47	<u>Quality Assurance Consultant</u>	Monthly	13,048	10-03	47
48					48
49	TOTAL (lines 35 - 48)	76	\$ 37,977		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Hickory Nursing Pavilion

Report Period Beginning: 01/01/05 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Hickory Nursing Pavilion

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC \$3,389.00
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? 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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,951 Line 10
- (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. N/A
- (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. \$ 40,515  
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. \$ 63,948 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
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? \_\_\_\_\_**  
**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 \$2500, 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.

SEE ACCOUNTANTS' COMPILATION REPORT