

		FOR BHF USE					

LL1

**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:** 0040436

**Facility Name:** Sterling Pavilion

**Address:** 105 East 23rd Street Sterling 61081  
 Number City Zip Code

**County:** Whiteside

**Telephone Number:** (815) 626-4264 **Fax #** (815) 626-3254

**HFS ID Number:** 363873072001

**Date of Initial License for Current Owners:** 04/01/93

**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

**Date:** 07/01/2005  
**To:** Administrator/Cost Report Preparer  
**From:** Bureau of Health Finance  
**Re:** 2005 Long Term Care Cost Report and Instructions

This year the cost report will be available by download from the Internet or by Email. If you require a disk, please call Fred Sosman at 217-782-1630. The web site for the download of the cost report file and instructions is <http://www.hfs.illinois.gov/costreports/>. Click on the Nursing Home and ICF/DD link. Next right-click on the "Excel version" and select, "Save Target As". Then save the file on your computer system in the location where you want it. Next, right-click on the instructions file and select "Save Target As". Then save the file on your computer system.

When you have completed the cost report, send in the completed cost report file by email, CD or disk. **The EMAIL address for sending in the Excel file is [aidd7608@mail.idpa.state.il.us](mailto:aidd7608@mail.idpa.state.il.us).** A signed paper copy must be sent in also. In order to provide for the efficient and accurate processing of any 7/01/06 - 6/30/07 Medicaid rates, the completed Excel cost report file must be sent in at the same time as the paper copy of the cost report.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2005. It is due on September 30, 2005, or 90 days after the close of the facility's fiscal year, whichever comes later. Please refer to the instructions for the remainder of the filing requirements.

Please use the 2005 cost report file and instructions. Printed copies of the report from the 2004 cost report or earlier files will NOT be accepted. In order to print the instructions on legal paper, open the Instr05.pdf file. Then click File-Page Setup. Change the paper size to legal and click OK. Otherwise, the instructions will print on letter size paper. The type may be a little small if letter size is used.

**IMPORTANT NOTICE for Those Facilities Receiving a Calendar 2004 Real Estate Tax Bill:** Located after page 10 of the cost report on the worksheet named "RE\_TAX" is the "2004 Long Term Care Real Estate Tax Statement." As in previous years, the real estate tax statement is being included in the cost report. A separate notice requesting the submittal of this statement and the calendar 2004 tax bill will not be sent. Please complete the "2004 Long Term Care Real Estate Tax Statement" and send it to our office along with the copies of the calendar 2004 real estate tax bills as an attachment to the fiscal 2005 cost report. Please Note: Copies of the original tax bills must be provided.

If both the "2004 Long Term Care Real Estate Tax Statement" and the corresponding tax bills are not included with the 2005 cost report, the Medicaid rate will not include a component for real estate taxes. Additionally, the cost report will not be considered complete and timely filed and may be subject to Medicaid payments being withheld.

**Cost Report File**  
Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility. Ensure that the 7 digit IDPH ID# is correct.) When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter "various" or other text in columns 2 or 3.

**Attachments**  
Please include all explanations, additional details and additional schedules, including the information for owners' compensation, on the worksheets in the cost report file. Separate worksheets have been included after page 23 for the recording of this type of detail. Additionally, you may also insert these sheets in the file behind the pages to which they correspond. Please do not change or delete the sheet names of pages 1 through 23, ReadMe or Macro. Also, do not change any range names or range references.

**Page 12 and Pages 12A through 12I**  
Pages 12A through 12I have been set up to carry forward the totals from the previous page 12. For example, if you use pages 12 through 12F, the total on page 12F will be your grand total building and improvements cost. Only the pages that you use will be printed when the "Print Entire Report" macro is selected.

**WARNING:** Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information. Print macros have been written that will print each individual page or the entire report.

The cost report must be printed on 8 1/2 by 14 size white paper with an 8 1/2 by 14 image on the paper. Please do not reduce the image to 8 1/2 by 11. We cannot accept a report with an 8 1/2 by 11 image. After printing the cost report, please review the copy for accuracy and completeness before mailing it to the Bureau of Health Finance. As part of the filing requirements, send the completed Excel file at the same time you send your paper copy. Also, please make sure both the completed file and the paper copy agree prior to sending them to our office.

**Cost Report File and Extra Pages**  
The entire cost report is in one file named Report05.xls. In an Excel file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the file, please call Randy Hulskotter at (217) 782-1630. You may also contact our office by email at the address located in the footer of this memo



**Shortcut=**  
Hold down  
Control Key and press m



**Shortcut=**  
Hold down  
Control Key and press q

**To Stop Macro:**  
Hold down  
Control Key and press "Break"

IF YOU WOULD LIKE THE NOTE, " SEE  
ACCOUNTANTS' COMPILATION REPORT"  
AT THE BOTTOM OF EVERY PAGE, ENTER  
THE NUMBER 1 IN CELL E4.

1

If you would like Pages Summary A and Summary B  
to print, change cell E11 to zero.

0

Facility Name & ID Number Sterling Pavilion# 0040436 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 N/A

	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>121</u>	Skilled (SNF)	<u>121</u>	<u>44,165</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>121</u>	TOTALS	<u>121</u>	<u>44,165</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>8,377</u>	<u>7,368</u>	<u>4,493</u>	<u>20,238</u>	8
9	SNF/PED					9
10	ICF	<u>14,322</u>	<u>3,609</u>	<u>48</u>	<u>17,979</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,699</u>	<u>10,977</u>	<u>4,541</u>	<u>38,217</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 86.53%

D. How many bed-hold days during this year were paid by the Department?

None (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)

N/AF. Does the facility maintain a daily midnight census? YesG. 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 4/1/93

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

YES  Date 4/1/93 NO 

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

YES  NO  If YES, enter number  
of beds certified 121 and days of care provided 4,408Medicare 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 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	166,208	10,457	7,080	183,745		183,745		183,745		1
2	Food Purchase		163,046		163,046		163,046	(1,025)	162,021		2
3	Housekeeping	120,005	32,779		152,784		152,784		152,784		3
4	Laundry	55,009	18,825		73,834		73,834		73,834		4
5	Heat and Other Utilities			127,180	127,180		127,180	1,019	128,199		5
6	Maintenance	56,850	38,153	49,664	144,667		144,667	4,022	148,689		6
7	Other (specify):*							555	555		7
8	<b>TOTAL General Services</b>	<b>398,072</b>	<b>263,260</b>	<b>183,924</b>	<b>845,256</b>		<b>845,256</b>	<b>4,571</b>	<b>849,827</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,454,690	55,414	7,030	1,517,134		1,517,134	(769)	1,516,365		10
10a	Therapy	47,046	540		47,586		47,586		47,586		10a
11	Activities	103,232	620		103,852		103,852		103,852		11
12	Social Services	42,022		7,526	49,548		49,548		49,548		12
13	CNA Training			380	380		380		380		13
14	Program Transportation	17,029			17,029		17,029		17,029		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,664,019</b>	<b>56,574</b>	<b>14,936</b>	<b>1,735,529</b>		<b>1,735,529</b>	<b>(769)</b>	<b>1,734,760</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	102,136		31,000	133,136		133,136	70,723	203,859		17
18	Directors Fees										18
19	Professional Services			344,542	344,542	(1,134)	343,408	(268,116)	75,292		19
20	Dues, Fees, Subscriptions & Promotions			38,165	38,165		38,165	(26,724)	11,441		20
21	Clerical & General Office Expenses	47,612	3,440	32,889	83,941		83,941	38,265	122,206		21
22	Employee Benefits & Payroll Taxes			300,534	300,534		300,534	(3,426)	297,108		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,771	2,771		2,771	(253)	2,518		24
25	Other Admin. Staff Transportation			2,064	2,064		2,064	1,137	3,201		25
26	Insurance-Prop.Liab.Malpractice			70,092	70,092		70,092	1,723	71,815		26
27	Other (specify):*							29,243	29,243		27
28	<b>TOTAL General Administration</b>	<b>149,748</b>	<b>3,440</b>	<b>822,057</b>	<b>975,245</b>	<b>(1,134)</b>	<b>974,111</b>	<b>(157,428)</b>	<b>816,683</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,211,839</b>	<b>323,274</b>	<b>1,020,917</b>	<b>3,556,030</b>	<b>(1,134)</b>	<b>3,554,896</b>	<b>(153,627)</b>	<b>3,401,269</b>		<b>29</b>

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

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 Sterling Pavilion #0040436 Report Period Beginning: 01/01/05 Ending: 12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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>D. Ownership</b>										
30	Depreciation			33,623	33,623		33,623	43,387	77,010		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			31,488	31,488		31,488	654,509	685,997		32
33	Real Estate Taxes			27,385	27,385	1,134	28,519	2,729	31,248		33
34	Rent-Facility & Grounds			708,294	708,294		708,294	(708,294)			34
35	Rent-Equipment & Vehicles			3,100	3,100		3,100	4,555	7,655		35
36	Other (specify):*							6,667	6,667		36
37	<b>TOTAL Ownership</b>			803,890	803,890	1,134	805,024	3,553	808,577		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	115,238	103,317	6,548	225,103		225,103	(1,162)	223,941		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			66,248	66,248		66,248		66,248		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>	115,238	103,317	72,796	291,351		291,351	(1,162)	290,189		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,327,077	426,591	1,897,603	4,651,271		4,651,271	(151,236)	4,500,035		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 Sterling Pavilion

# 0040436

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	(114,083)	30		9
10	Interest and Other Investment Income	(15,107)	32		10
11	Discounts, Allowances, Rebates & Refunds	(560)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(465)	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				18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(25,911)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,826)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(30,570)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (189,523)		\$	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)	38,287		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 38,287		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (151,236)		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

Sterling Pavilion  
 ID# 0040436  
 Report Period Beginning: 01/01/05  
 Ending: 12/31/05

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Bank Charges	\$ (7,126)	21	1
2 Collection Fees	(117)	21	2
3 Building Co. - Bank Charges	(400)	21	3
4 Building Co. - Trust Fees	(150)	21	4
5 C&P Fees	991	20	5
6 Capitalized R&M	(4,147)	06	6
7 Non-Care Asset Depreciation	(6,572)	30	7
8 Non-Allowable Seminar	(588)	24	8
9 Non-Allowable Travel Expenses	(220)	25	9
10 Non-Allowable Legal Fees	(6,237)	19	10
11 PPA-Office Expense	(222)	21	11
12 PPA-Employee Benefits	(3,426)	22	12
13 PPA-Ancillary	(587)	29	13
14 PPA-Maintenance	(437)	06	14
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98			98
99			99
100			100
101 Total	(30,570)		101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Sterling Pavilion

# 0040436

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	(1,025)											(1,025)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,019									1,019	5
6	Maintenance	(4,584)		2,901	5,705								4,022	6
7	Other (specify):*					555							555	7
8	<b>TOTAL General Services</b>	<b>(5,609)</b>		<b>3,920</b>	<b>5,705</b>	<b>555</b>							<b>4,571</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records						(769)						(769)	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>(769)</b>						<b>(769)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(31,000)	101,723								70,723	17
18	Directors Fees													18
19	Professional Services	(6,237)		(261,879)									(268,116)	19
20	Fees, Subscriptions & Promotions	(27,502)		778									(26,724)	20
21	Clerical & General Office Expenses	(9,841)	550	41,284	6,272								38,265	21
22	Employee Benefits & Payroll Taxes	(3,426)											(3,426)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(338)		85									(253)	24
25	Other Admin. Staff Transportation	(220)		1,357									1,137	25
26	Insurance-Prop.Liab.Malpractice			1,723									1,723	26
27	Other (specify):*			8,526		20,717							29,243	27
28	<b>TOTAL General Administration</b>	<b>(47,564)</b>	<b>550</b>	<b>(239,126)</b>	<b>107,995</b>	<b>20,717</b>							<b>(157,428)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(53,174)</b>	<b>550</b>	<b>(235,206)</b>	<b>113,700</b>	<b>21,272</b>	<b>(769)</b>						<b>(153,627)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Sterling Pavilion

# 0040436

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	(120,655)	161,762	2,280									43,387	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(15,107)	667,067	2,549									654,509	32
33	Real Estate Taxes			2,729									2,729	33
34	Rent-Facility & Grounds		(708,294)										(708,294)	34
35	Rent-Equipment & Vehicles			4,555									4,555	35
36	Other (specify):*		6,667										6,667	36
37	<b>TOTAL Ownership</b>	<b>(135,762)</b>	<b>127,202</b>	<b>12,113</b>									<b>3,553</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(587)					(575)						(1,162)	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>(587)</b>					<b>(575)</b>						<b>(1,162)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(189,523)</b>	<b>127,752</b>	<b>(223,093)</b>	<b>113,700</b>	<b>21,272</b>	<b>(1,344)</b>						<b>(151,236)</b>	<b>45</b>

Facility Name & ID Number Sterling Pavilion

# 0040436

Report Period Beginning:

01/01/05

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12/31/05

**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	\$ 708,294	Sterling Building LLC		\$	\$ (708,294)	1
2	V	32 Interest Expense		Sterling Building LLC		667,067	667,067	2
3	V	30 Depreciation Expense		Sterling Building LLC		161,762	161,762	3
4	V	36 Amortization		Sterling Building LLC		6,667	6,667	4
5	V	21 Franchise Tax		Sterling Building LLC		400	400	5
6	V	21 Trust Fees		Sterling Building LLC		150	150	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 708,294			\$ 836,046	\$ * 127,752	14

\* 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	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 1,019	\$ 1,019	15
16	V	6 REPAIRS & MAINT.				2,901	2,901	16
17	V	19 PROFESSIONAL FEES				2,121	2,121	17
18	V	20 DUES AND SUBSCRIPTIONS				778	778	18
19	V	21 CLERICAL & GENERAL				41,284	41,284	19
20	V	24 SEMINARS AND TRAVEL				85	85	20
21	V	25 AUTO EXP.				1,357	1,357	21
22	V	26 INSURANCE				1,723	1,723	22
23	V	27 EMP.BEN. - GEN. ADMIN.				8,526	8,526	23
24	V	30 DEPRECIATION				2,280	2,280	24
25	V	32 INTEREST				2,549	2,549	25
26	V	33 REAL ESTATE TAXES				2,729	2,729	26
27	V	35 EQUIPMENT RENTAL				4,555	4,555	27
28	V	19 BOOKKEEPING SERVICES	264,000				(264,000)	28
29	V	17 MANAGEMENT FEES	31,000				(31,000)	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		\$ 295,000			\$ 71,907	\$ * (223,093)	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	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 5,705	\$ 5,705	15
16	V	17 ADMIN. CMP. - M. MAUER				15,725	15,725	16
17	V	17 ADMIN. CMP. - M. AARON				17,595	17,595	17
18	V	17 ADMIN. CMP. - F. AARON				15,064	15,064	18
19	V	17 ADMIN. CMP. - S. GOLDSTEIN						19
20	V	17 ADMIN. CMP. - S. KOPLIN				10,250	10,250	20
21	V	17 ADMIN. CMP. - D. MAGAFAS				10,813	10,813	21
22	V	17 ADMIN. CMP. - S. LEVY				14,644	14,644	22
23	V	17 ADMIN. CMP. - HOWARD ALTER						23
24	V	17 ADMIN. CMP. - NON-OWNER				17,632	17,632	24
25	V	21 CLERICAL CMP. - S. AARON				6,272	6,272	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		\$			\$ 113,700	\$ * 113,700	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	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 555	\$ 555	15
16	V	27 EMP. BEN.- M. MAUER				1,076	1,076	16
17	V	27 EMP. BEN.- M. AARON				1,401	1,401	17
18	V	27 EMP. BEN.- F. AARON				7,199	7,199	18
19	V	27 EMP. BEN.- S. GOLDSTEIN						19
20	V	27 EMP. BEN.- S. KOPLIN				3,588	3,588	20
21	V	27 EMP. BEN.- D. MAGAFAS				875	875	21
22	V	27 EMP. BEN.- S. LEVY				2,296	2,296	22
23	V	27 EMP. BEN.- HOWARD ALTER						23
24	V	27 EMP. BEN.- NON-OWNER				2,893	2,893	24
25	V	27 EMP. BEN. - S. AARON				1,389	1,389	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		\$			\$ 21,272	\$ * 21,272	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	10 MEDICAL SUPPLIES	2,637	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	1,868	(769)	16
17	V	39 ANCILLARY EXPENSE	1,972	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	1,397	(575)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 4,609			\$ 3,265	\$ * (1,344)	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			\$			\$	\$ *	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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number  Sterling Pavilion

#  0040436

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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number  Sterling Pavilion

#  0040436

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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number  Sterling Pavilion

#  0040436

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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Sterling Pavilion

#

0040436

Report Period Beginning:

01/01/05

Ending:

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## 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	Maurice Aaron	Owner	Administrative	22.23%	See Attached	4.14	10.35%	Allocated	\$ 17,595	17-7	1
2	Marshall Mauer	Owner	Administrative	8.26%	See Attached	3.70	9.25%	Allocated	15,725	17-7	2
3	Sue Koplín	Owner	Administrative	0.39%	See Attached	5.66	14.15%	Allocated	10,250	17-7	3
4	Diana Magafas	Owner	Administrative	0.39%	See Attached	4.65	11.63%	Allocated	10,813	17-7	4
5	Dennis Nehmer	Owner	Maintenance	0.39%	See Attached	4.14	10.35%	Allocated	5,705	6-7	5
6	Sharon Aaron	Owner	Clerical	0.39%	See Attached	3.70	9.25%	Allocated	6,272	21-7	6
7	Fred Aaron	Owner	Administrative	23.80%	See Attached	8.00	17.02%	Alloc./Sal	26,064	17-1,17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 92,424		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  Sterling Pavilion

#  0040436  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 Sterling Pavilion

# 0040436

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 DYNAMIC HEALTH CARE CONS.  
 Street Address 3359 W. MAIN STREET  
 City / State / Zip Code SKOKIE, IL. 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	413,836	12	\$ 11,039	\$ 38,217	\$ 1,019	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	413,836	12	31,419	38,217	2,901	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	413,836	12	22,969	38,217	2,121	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	413,836	12	8,420	38,217	778	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	413,836	12	447,045	345,326	41,284	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	413,836	12	917	38,217	85	6
7	25	AUTO EXP.	PATIENT DAYS	413,836	12	14,696	38,217	1,357	7
8	26	INSURANCE	PATIENT DAYS	413,836	12	18,661	38,217	1,723	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	413,836	12	92,321	38,217	8,526	9
10	30	DEPRECIATION	PATIENT DAYS	413,836	12	24,690	38,217	2,280	10
11	32	INTEREST	PATIENT DAYS	413,836	12	27,602	38,217	2,549	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	413,836	12	29,555	38,217	2,729	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	413,836	12	49,319	38,217	4,555	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				\$ 778,653	\$ 345,326		\$ 71,907	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

# 0040436

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 DYNAMIC HEALTH CARE CONS.  
 Street Address 3359 W. MAIN STREET  
 City / State / Zip Code SKOKIE, IL. 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	55,120	55,120	4	5,705	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	170,000	170,000	4	15,725	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	170,000	170,000	4	17,595	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	47	6	88,500	88,500	8	15,064	4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	24,000	24,000			5
6	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	7	72,485	72,485	6	10,250	6
7	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	104,642	104,642	5	10,813	7
8	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	11	158,233	158,233	4	14,644	8
9	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	9	170,636	170,636	5	17,632	10
11	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	67,785	67,785	4	6,272	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					\$ 1,093,401	\$ 1,093,399		\$ 113,700	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

# 0040436

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 DYNAMIC HEALTH CARE CONS.  
 Street Address 3359 W. MAIN STREET  
 City / State / Zip Code SKOKIE, IL. 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	5,362	4	555	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,631	4	1,076	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	13,532	4	1,401	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	47	6	42,295	8	7,199	4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	33,649			5
6	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	7	25,376	6	3,588	6
7	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	8,470	5	875	7
8	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	11	24,807	4	2,296	8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,105			9
10	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	9	27,997	5	2,893	10
11	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	15,016	4	1,389	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					\$ 209,240	\$	\$ 21,272	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

# 0040436

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 LINCOLN MEDICAL SUPPLIES, INC.  
 Street Address 3359 W. MAIN STREET  
 City / State / Zip Code SKOKIE, IL. 60076  
 Phone Number ( 847) 679-8219  
 Fax Number ( 847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2	10	MEDICAL SUPPLIES						1,868	2
3	39	ANCILLARY EXPENSE						1,397	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 3,265	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

# 0040436 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  Sterling Pavilion

#  0040436  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  Sterling Pavilion

#  0040436  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  Sterling Pavilion

#  0040436  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  Sterling Pavilion

#  0040436  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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					
		<b>A. Directly Facility Related</b>											
<b>Long-Term</b>													
1	<u>Sterling Building, LLC</u>	<u>X</u>		<u>Capitalized Leases</u>			\$	<u>6,647,065</u>			\$	<u>667,067</u>	1
2													2
3													3
4													4
5	<u>See Supplemental Schedule</u>												5
<b>Working Capital</b>													
6	<u>Manufacturers Bank</u>		<u>X</u>	<u>Line Of Credit</u>				<u>550,000</u>				<u>29,578</u>	6
7				<u>Insurance Financing</u>								<u>1,910</u>	7
8	<u>See Supplemental Schedule</u>												8
9	<b>TOTAL Facility Related</b>						\$	<u>7,197,065</u>			\$	<u>698,555</u>	9
<b>B. Non-Facility Related*</b>													
10	<u>Interest Income</u>		<u>X</u>									<u>(15,107)</u>	10
11	<u>Allocated - Dynamic Healthc</u>											<u>2,549</u>	11
12													12
13	<u>See Supplemental Schedule</u>												13
14	<b>TOTAL Non-Facility Related</b>						\$				\$	<u>(12,558)</u>	14
15	<b>TOTALS (line 9+line14)</b>						\$	<u>7,197,065</u>			\$	<u>685,997</u>	15

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

\* 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.)

Facility Name & ID Number

Sterling Pavilion

# 0040436

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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						\$	\$			\$	15									
16											16									
17											17									
18											18									
19											19									
20	<b>TOTAL Non-Facility Related</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

1. Real Estate Tax accrual used on 2004 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>34,000</b>	1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	<b>33,114</b>	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(886)</b>	3																			
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>31,000</b>	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>1,134</b>	5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>31,248</b>	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:																								
2000	<u>29,219</u>	<u>8</u>	<table border="1"> <tr> <td colspan="3"><b>FOR OHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			<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
<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																					
2001	<u>29,503</u>	<u>9</u>																						
2002	<u>30,527</u>	<u>10</u>																						
2003	<u>32,600</u>	<u>11</u>																						
2004	<u>30,385</u>	<u>12</u>																						
<u>2005 Accrual = \$30,385 x 1.02 = \$31,000</u>																								
<u>Allocated - Dynamic Healthcare = \$2,762</u>																								

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 Sterling Pavilion COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0040436

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>11-16-402-001</u>	<u>Long Term Care Property</u>	\$ <u>29,107.74</u>	\$ <u>29,108.74</u>
2. <u>11-16-402-013</u>	<u>Long Term Care Property</u>	\$ <u>1,276.52</u>	\$ <u>1,276.52</u>
3. <u>10-23-404-059-0000</u>	<u>Allocated Home Office</u>	\$ <u>29,908.15</u>	\$ <u>2,761.96</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>60,292.41</u>	\$ <u>33,147.22</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.



Facility Name & ID Number Sterling Pavilion

# 0040436 Report Period Beginning:

01/01/05 Ending:

12/31/05

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 35,000 B. General Construction Type: Exterior Brick Frame Steel/Concrete 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).

None

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	<u>Facility</u>			\$ <u>48,888</u>	1
2	<u>Alloc. Building Co.</u>			<u>100,000</u>	2
3	<b>TOTALS</b>	<b>#VALUE!</b>		\$ <b>148,888</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

# 0040436

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			1993	18,723		20	938	938	11,812	9
10	Various			1994	6,356		20	319	319	3,691	10
11	Various			1995	13,538		20	677	677	6,987	11
12	Various			1996	33,635		20	1,681	1,681	15,612	12
13	Various			1997	65,081		20	3,255	3,255	27,399	13
14	Various			1998	86,428		20	4,323	4,323	32,099	14
15	Various			1999	77,777		20	3,858	3,858	25,867	15
16	Various			2000	11,922		20	597	597	3,206	16
17	Various			2001	31,146		20	1,558	1,558	6,997	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*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 Sterling Pavilion

# 0040436

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
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57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		6,052,408	155,190			(155,190)	1,778,219	67
68		40,966	1,050		1,170	120	14,435	68
69			33,623			(33,623)		69
70		\$ 6,437,980	\$ 189,863		\$ 18,376	\$ (171,487)	\$ 1,926,324	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 Sterling Pavilion

**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>		\$ 6,437,980	\$ 189,863		\$ 18,376	\$ (171,487)	\$ 1,926,324	1
2	Garage	2002	54,605		20	5,461	5,461	20,932	2
3	Wall Heater	2002	504		20	50	50	197	3
4	Phone Wiring Garage	2002	950		20	95	95	348	4
5	Wall Vinyl	2002	4,190		20	419	419	1,501	5
6	Refrigerator Compressor	2002	715		20	72	72	256	6
7	Flooring	2002	832		20	83	83	291	7
8	Drain Piping	2002	887		20	89	89	310	8
9	Rooftop Compressors	2002	3,423		20	342	342	1,198	9
10	Rooftop Compressor	2002	1,502		20	150	150	513	10
11	Keypads For Doors	2002	1,486		20	149	149	520	11
12	Blinds	2002	1,683		20	168	168	589	12
13	Blinds	2002	340		20	34	34	116	13
14	Blinds	2002	289		20	29	29	99	14
15	Window Treatments	2002	9,612		20	961	961	3,204	15
16	Circuit Board Security	2002	1,256		20	126	126	419	16
17	Countertops	2002	1,925		20	193	193	642	17
18	Wall Vinyl	2002	1,294		20	129	129	421	18
19	Fireplace	2002	1,761		20	176	176	572	19
20	Handrails & Bumpers	2002	4,624		20	462	462	1,426	20
21	Painting	2002	533		20	53	53	187	21
22	Wallpaper	2002	585		20	59	59	210	22
23	Wallpaper	2002	2,436		20	244	244	853	23
24	Ac Repairs	2002	545		20	55	55	195	24
25	Ac Repairs	2002	1,708		20	171	171	569	25
26	Valve Repairs	2002	981		20	98	98	311	26
27	Motor	2002	1,200		20	120	120	370	27
28	Doors	2003	5,532		20	553	553	1,567	28
29	Remodel Bathroom	2003	1,418		20	142	142	402	29
30	Bathroom Remodeling	2003	8,563		20	856	856	2,426	30
31	Floor Tile	2003	1,472		20	147	147	417	31
32	Overbed Lights	2003	651		20	65	65	174	32
33	Window Treatments	2003	3,269		20	327	327	872	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,558,751	\$ 189,863		\$ 30,454	\$ (159,409)	\$ 1,968,431	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Sterling Pavilion

**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>		\$ 6,558,751	\$ 189,863		\$ 30,454	\$ (159,409)	\$ 1,968,431	1
2	Rewire Fire Panel	2003	2,132		20	213	213	533	2
3	Door Contacts For Wanderguard Sys	2003	2,942		20	294	294	662	3
4	2 Entrance & Doors	2003	10,605		20	1,061	1,061	2,386	4
5	Variance On 2001 Asset	2003	(2,085)		20	(209)	(209)	(626)	5
6	Condensor Repairs	2003	505		20	51	51	126	6
7	Generator	2003	833		20	83	83	174	7
8	Heating Repairs	2003	1,670		20	167	167	348	8
9	Heating Repairs	2003	2,431		20	243	243	506	9
10	Remodel Bathroom	2004	2,794		20	279	279	559	10
11	Remodel Bathroom	2004	4,713		20	471	471	903	11
12	Remodel Bathroom	2004	4,310		20	431	431	826	12
13	Tile For Bathroom Remodel	2004	1,155		20	116	116	231	13
14	Mixing Valve For Water System	2004	964		20	96	96	169	14
15	Black Top Entrance	2004	4,700		20	470	470	823	15
16	2 Hot Water Heaters	2004	8,691		20	869	869	1,231	16
17	Condensing Unit	2004	4,903		20	490	490	695	17
18	A/C & Hot Water Heater	2004	4,111		20	411	411	582	18
19	Parts Fro Install Of Hot Water Heaters	2004	1,302		20	130	130	184	19
20	Parts For Install Of Hot Water Heaters	2004	1,452		20	145	145	194	20
21	Generator Board	2004	2,077		20	208	208	242	21
22	Hosp. Inc. Tile	2004	1,112		20	111	111	130	22
23	Refrigerator - Walk In Freezer	2004	4,500		20	450	450	488	23
24	Motor, Thermostats, Capcaitors, Blower Motors	2004	1,515		20	151	151	303	24
25	12 Overbed Lights With Pull Chain	2004	1,191		20	119	119	208	25
26	12 Overbed Lights With Pull Chain	2004	1,131		20	113	113	188	26
27	Alarm - Tone Generator	2004	594		20	59	59	94	27
28	Leak Repair And Control Valve	2004	703		20	70	70	111	28
29	Motor	2004	952		20	95	95	151	29
30	10 Thermostats	2004	695		20	69	69	87	30
31	Overhead Light	2005	1,339		20	112	112	112	31
32	Install Fire Alarm System	2005	1,596		20	171	171	171	32
33	Water Line Replacement	2005	1,175		20	69	69	69	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,635,459	\$ 189,863		\$ 38,062	\$ (151,801)	\$ 1,981,291	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

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	Totals from Page 12C, Carried Forward		\$ 6,635,459	\$ 189,863		\$ 38,062	\$ (151,801)	\$ 1,981,291	1
2	Concrete For Sidewalk	2005	518		20	30	30	30	2
3	Concrete For Sidewalk	2005	259		20	10	10	10	3
4	Concrete For Sidewalk	2005	239		20	8	8	8	4
5	Fire Alarm Door Magnetic Lock	2005	1,899		20	136	136	136	5
6	Fire Alarm Door Contacts	2005	892		20	64	64	64	6
7	Replaced Water Service	2005	1,904		20	79	79	79	7
8	Air Conditioners	2005	2,325		20	194	194	194	8
9	Bathroom Remodeling	2005	3,563		20	89	89	89	9
10	Bathroom Remodeling	2005	1,188		20	30	30	30	10
11	Overbed Light	2005	1,448		20	36	36	36	11
12	Installation Of Video Equipment	2005	4,853		20	116	116	116	12
13	Hvac	2005	4,147		20	86	86	86	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

# 0040436

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	Totals from Page 12D, Carried Forward		\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169	1
2									2
3									3
4									4
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6									6
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9									9
10									10
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12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

# 0040436

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	Totals from Page 12E, Carried Forward	\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

# 0040436

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	Totals from Page 12F, Carried Forward	\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

# 0040436

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	
1		\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169	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
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19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

# 0040436

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	Totals from Page 12H, Carried Forward	\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169		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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

# 0040436

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	Totals from Page 12I, Carried Forward		\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

# 0040436

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	
1		\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169	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
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,658,694	\$ 189,863		\$ 38,940	\$ (150,923)	\$ 1,982,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

**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			1994	1974	\$ 6,052,408	\$ 155,190	35	\$	\$ (155,190)	\$ 1,778,219	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
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

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	TOTAL (lines 4 thru 69)	\$ 6,052,408	\$ 155,190		\$	\$ (155,190)	\$ 1,778,219	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

# 0040436

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		1993	1993	\$ 40,966	\$ 1,050	35	\$ 1,170	\$ 120	\$ 14,435	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
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

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	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		40,966	1,050		1,170	120	14,435	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion # 0040436 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	\$ 680,807	\$ 203	\$ 33,724	\$ 33,521	10	\$ 566,577	71
72	Current Year Purchases	26,516		3,272	3,272	10	3,272	72
73	Fully Depreciated Assets	39,722				10	39,722	73
74								74
75	TOTALS	\$ 747,045	\$ 203	\$ 36,996	\$ 36,793		\$ 609,571	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	BUS	2000	\$ 45,441	\$	\$	\$	5	\$ 45,441	76
77	Allocated - Dynamic	Auto - Allocated	2005	15,924	1,026	1,073	47	5	1,026	77
78										78
79										79
80	TOTALS			\$ 61,365	\$ 1,026	\$ 1,073	\$ 47		\$ 46,467	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)	\$ 7,615,992	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 191,092	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 77,009	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (114,083)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,638,207	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	Building - 2004	\$ 256,308	\$ 6,572	\$ 6,271	86
87	Land - 2004	4,235			87
88					88
89					89
90					90
91	TOTALS	\$ 260,543	\$ 6,572	\$ 6,271	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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 7,655 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

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

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

\* 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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		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		380		380
8	CNA Competency Tests				
9	TOTALS	\$	\$ 380	\$	\$ 380
10	SUM OF line 9, col. 1 and 2 (e)	\$	380		

**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

Facility Name & ID Number Sterling Pavilion# 0040436 Report Period Beginning:01/01/05 Ending:12/31/05

## 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 - 01	hrs	\$ 76,112		\$	\$		\$ 76,112	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,548			6,548	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	39,126					39,126	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				93,392		93,392	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>						9,925		9,925	13
14	<b>TOTAL</b>			\$ 115,238		\$ 6,548	\$ 103,317		\$ 225,103	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 Sterling Pavilion# 0040436Report 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	\$ 2,250	\$ 2,334	1
2	Cash-Patient Deposits	48,479	48,479	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	774,910	774,910	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,059	44,059	6
7	Other Prepaid Expenses	2,260	2,260	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify): <u>See Attached Schedule</u>	28,794	40,894	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,100,752	\$ 1,112,936	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	48,887	153,122	13
14	Buildings, at Historical Cost		6,308,716	14
15	Leasehold Improvements, at Historical Cost	482,254	482,254	15
16	Equipment, at Historical Cost	409,591	772,591	16
17	Accumulated Depreciation (book methods)	(470,452)	(2,645,353)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,498	6,498	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,498)	(6,498)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	237,779	31,208	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 708,059	\$ 5,102,538	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,808,811	\$ 6,215,474	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 219,182	\$ 219,182	26
27	Officer's Accounts Payable	62,500	62,500	27
28	Accounts Payable-Patient Deposits	48,479	48,479	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	236,696	236,696	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,664	1,664	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,000	31,000	32
33	Accrued Interest Payable	2,673	2,673	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,889	9,889	35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 612,083	\$ 612,083	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	550,000	550,000	39
40	Mortgage Payable		6,647,065	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 (sum of lines 39 thru 44)</b>	\$ 550,000	\$ 7,197,065	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,162,083	\$ 7,809,148	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 646,728	\$ (1,593,674)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,808,811	\$ 6,215,474	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 632,828	1
2	Restatements (describe):		2
3	Depreciation	4,305	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 637,133	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	82,195	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	(72,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 9,595	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 646,728	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion# 0040436Report Period Beginning: 01/01/05Ending: 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	\$ 4,665,658	1
2	Discounts and Allowances for all Levels	(733,582)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,932,076	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	624,850	6
7	Oxygen	2,031	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 626,881	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	139,994	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,912	19
20	Radiology and X-Ray	1,125	20
21	Other Medical Services	10,811	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 158,842	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	15,107	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 15,107	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	560	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 560	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,733,466	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	845,256	31
32	Health Care	1,735,529	32
33	General Administration	975,245	33
<b>B. Capital Expense</b>			
34	Ownership	803,890	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	225,103	35
36	Provider Participation Fee	66,248	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,651,271	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	82,195	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 82,195	43

\* 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 Sterling Pavilion

# 0040436

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	1,774	2,187	\$ 63,601	\$ 29.08	1
2	Assistant Director of Nursing	2,009	2,105	51,105	24.28	2
3	Registered Nurses	3,911	4,389	88,088	20.07	3
4	Licensed Practical Nurses	22,943	25,188	476,087	18.90	4
5	CNAs & Orderlies	69,059	72,506	751,995	10.37	5
6	CNA Trainees					6
7	Licensed Therapist	2,139	2,139	115,238	53.87	7
8	Rehab/Therapy Aides	3,259	3,692	47,046	12.74	8
9	Activity Director	3,533	3,795	41,760	11.00	9
10	Activity Assistants	7,985	8,340	61,472	7.37	10
11	Social Service Workers	3,341	3,599	42,022	11.68	11
12	Dietician					12
13	Food Service Supervisor	2,009	2,097	25,731	12.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,485	19,357	140,477	7.26	15
16	Dishwashers					16
17	Maintenance Workers	3,958	4,251	56,850	13.37	17
18	Housekeepers	14,246	15,366	120,005	7.81	18
19	Laundry	6,760	7,068	55,009	7.78	19
20	Administrator	1,937	2,097	91,136	43.46	20
21	Assistant Administrator					21
22	Other Administrative	416	416	11,000	26.44	22
23	Office Manager					23
24	Clerical	3,975	4,668	47,612	10.20	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	2,015	2,552	23,814	9.33	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,085	2,132	17,029	7.99	33
34	<b>TOTAL (lines 1 - 33)</b>	<b>175,839</b>	<b>187,944</b>	<b>\$ 2,327,077 *</b>	<b>\$ 12.38</b>	<b>34</b>

\* 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	201	\$ 7,080	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	176	7,030	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	141	7,526	12-03	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>518</b>	<b>\$ 21,636</b>		<b>49</b>

**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	<b>TOTAL (lines 50 - 52)</b>			<b>53</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

# 0040436

Report Period Beginning: 01/01/05

Ending: 12/31/05

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Rhonda Reed	Administrator	0	\$ 91,136	Workers' Compensation Insurance	\$ 65,138	IDPH License Fee	\$	
Fred Aaron	Administrative	23.08%	11,000	Unemployment Compensation Insurance	21,562	Advertising: Employee Recruitment	754	
				FICA Taxes	173,023	Health Care Worker Background Check	860	
				Employee Health Insurance	29,580	(Indicate # of checks performed <u>72</u> )		
				Employee Meals		Licenses & Fees	2,779	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,270	
				Other Employee Benefits	7,805	Allocated - Dynamic Healthcare	778	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 102,136					
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
Dynamic Healthcare Consultants			\$ 31,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 31,000				Seminar Expense	2,433
(Attach a copy of any management service agreement)							Allocated - Dynamic	85
C. Professional Services			TOTAL (agree to Schedule V, line 22, col.8) <th colspan="3">TOTAL (agree to Sch. V, line 20, col. 8) </th>			TOTAL (agree to Sch. V, line 20, col. 8)		
Vendor/Payee	Type		Amount			Amount		Amount
FR&R	Accounting		\$ 9,550					
Bona Fide Reporting Company	Legal		101					
Ogletree Deakins	Legal		6,156					
Sachnoff & Weaver	Legal		11,978					
Sarnoff & Bacash	Legal		1,134					
Seyfarth Shaw	Legal		34,716					
Texnet Court Reporters	Legal		1,283					
Ward Murray Pace	Legal		6,237					
Dynamic Healthcare Cons.	Bookkeeping Service		264,000					
Health Data Systems	Data Processing		3,647					
Robinson & Associates	Computer Support		1,740					
See Supplemental Schedule			3,999					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 344,541					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Sterling 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													
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12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Sterling Pavilion

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ILCLTC \$6,270
- (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? N/A
- (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. \$ 2,815 Line 10-02
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 66,248  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 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? 100% Ln 14  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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