

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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 01/01/06 to 12/31/06 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) _____	
<b>Paid Preparer</b>	(Title) _____	
	(Signed) _____	(Date) _____
<b>Paid Preparer</b>	(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u>	Fax # <u>(847) 236-1155</u>
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

# 0040436 Report Period Beginning: 01/01/06 Ending: 12/31/06

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>8,784</u>	<u>8,423</u>	<u>3,851</u>	<u>21,058</u>	8
9	SNF/PED					9
10	ICF	<u>10,682</u>	<u>2,976</u>	<u>378</u>	<u>14,036</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,466</u>	<u>11,399</u>	<u>4,229</u>	<u>35,094</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.46%

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/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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

YES  NO

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

Date started 04/01/93

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

YES  Date 04/01/93 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 3,795

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	174,469	9,584	6,792	190,845		190,845		190,845		1
2	Food Purchase		148,228		148,228		148,228	(481)	147,747		2
3	Housekeeping	116,124	34,203		150,327		150,327		150,327		3
4	Laundry	49,862	14,449		64,311		64,311		64,311		4
5	Heat and Other Utilities			120,307	120,307		120,307	909	121,216		5
6	Maintenance	59,879	40,760	40,129	140,768		140,768	6,662	147,430		6
7	Other (specify):*							528	528		7
8	<b>TOTAL General Services</b>	<b>400,334</b>	<b>247,224</b>	<b>167,228</b>	<b>814,786</b>		<b>814,786</b>	<b>7,618</b>	<b>822,404</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,520	2,520		2,520		2,520		9
10	Nursing and Medical Records	1,419,691	53,906	5,440	1,479,037		1,479,037	(342)	1,478,695		10
10a	Therapy	51,049	314	125	51,488		51,488		51,488		10a
11	Activities	106,553	1,613		108,166		108,166		108,166		11
12	Social Services	49,472		8,148	57,620		57,620		57,620		12
13	CNA Training										13
14	Program Transportation	19,350		25	19,375		19,375		19,375		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,646,115</b>	<b>55,833</b>	<b>16,258</b>	<b>1,718,206</b>		<b>1,718,206</b>	<b>(342)</b>	<b>1,717,864</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	102,112			102,112		102,112	84,978	187,090		17
18	Directors Fees										18
19	Professional Services			358,530	358,530		358,530	(312,213)	46,317		19
20	Dues, Fees, Subscriptions & Promotions			43,942	43,942		43,942	(33,113)	10,829		20
21	Clerical & General Office Expenses	28,051	2,357	48,105	78,513		78,513	27,049	105,562		21
22	Employee Benefits & Payroll Taxes			293,048	293,048		293,048		293,048		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,148	1,148		1,148	154	1,302		24
25	Other Admin. Staff Transportation			4,578	4,578		4,578	844	5,422		25
26	Insurance-Prop.Liab.Malpractice			69,383	69,383		69,383	3,443	72,826		26
27	Other (specify):*							27,149	27,149		27
28	<b>TOTAL General Administration</b>	<b>130,163</b>	<b>2,357</b>	<b>818,734</b>	<b>951,254</b>		<b>951,254</b>	<b>(201,709)</b>	<b>749,545</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,176,612</b>	<b>305,414</b>	<b>1,002,220</b>	<b>3,484,246</b>		<b>3,484,246</b>	<b>(194,433)</b>	<b>3,289,813</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: 01/01/06 Ending: 12/31/06

## 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			39,503	39,503	39,503	42,943	82,446				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,451	49,451	49,451	631,755	681,206				32
33	Real Estate Taxes			30,194	30,194	30,194	2,791	32,985				33
34	Rent-Facility & Grounds			721,244	721,244	721,244	(721,244)					34
35	Rent-Equipment & Vehicles			2,938	2,938	2,938	5,046	7,984				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			843,330	843,330	843,330	(38,709)	804,621				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	85,722	100,564	3,718	190,004	190,004	(4,159)	185,845				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>	85,722	100,564	69,966	256,252	256,252	(4,159)	252,093				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,262,334	405,978	1,915,516	4,583,828	4,583,828	(237,301)	4,346,527				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: 01/01/06

Ending: 12/31/06

**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	(119,722)	30		9
10	Interest and Other Investment Income	(26,811)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(481)	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	(46)	21		18
19	Entertainment				19
20	Contributions	(1,105)	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	(27,493)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,841)	20		28
29	Other-Attach Schedule	(44,205)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (222,705)		\$	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)	(14,596)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (14,596)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (237,301)		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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Bank Charges	\$ (15,357)	21	1
2 Interest Expense	(2,771)	32	2
3 Non-Allowable Legal	(180)	19	3
4 C/PE Fees	(2,251)	20	4
5 RCM Capitalization	(2,479)	06	5
6 Bank Charges - Building Company	(89)	21	6
7 Non-Care Asset Depreciation	(6,572)	30	7
8 PPA-Office Expense	(3,521)	21	8
9 PPA-RAM	(252)	06	9
10 PPA-Pharmacy	(4)	39	10
11 PPA-Lab	(1,986)	39	11
12 PPA-Speech Therapy	(624)	39	12
13 PPA-X Rays	(955)	39	13
14 Franchise Tax-Building Company	(250)	21	14
15 Amortization Expense-Building Company	(6,667)	26	15
16 Non-Allowable Travel Expense	(39)	25	16
17			17
18			18
19			19
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98			98
99			99
100			100
101 Total	(44,205)		101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Sterling Pavilion

# 0040436

Report Period Beginning:

01/01/06

Ending:

12/31/06

## 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	(481)											(481)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			909									909	5
6	Maintenance	(3,131)		4,419	5,374								6,662	6
7	Other (specify):*					528							528	7
8	<b>TOTAL General Services</b>	<b>(3,612)</b>		<b>5,328</b>	<b>5,374</b>	<b>528</b>							<b>7,618</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records						(342)						(342)	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>(342)</b>						<b>(342)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative				84,978								84,978	17
18	Directors Fees													18
19	Professional Services	(180)		(312,033)									(312,213)	19
20	Fees, Subscriptions & Promotions	(33,690)		577									(33,113)	20
21	Clerical & General Office Expenses	(19,063)	339	39,646	6,127								27,049	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			154									154	24
25	Other Admin. Staff Transportation	(39)		883									844	25
26	Insurance-Prop.Liab.Malpractice			3,443									3,443	26
27	Other (specify):*			7,403		19,746							27,149	27
28	<b>TOTAL General Administration</b>	<b>(52,972)</b>	<b>339</b>	<b>(259,927)</b>	<b>91,105</b>	<b>19,746</b>							<b>(201,709)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(56,584)</b>	<b>339</b>	<b>(254,599)</b>	<b>96,479</b>	<b>20,274</b>	<b>(342)</b>						<b>(194,433)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Sterling Pavilion

# 0040436

Report Period Beginning:

01/01/06 Ending:

Summary B

12/31/06

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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(126,294)	161,762	7,475									42,943	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(29,582)	659,149	2,188									631,755	32
33	Real Estate Taxes			2,791									2,791	33
34	Rent-Facility & Grounds		(721,244)										(721,244)	34
35	Rent-Equipment & Vehicles			5,046									5,046	35
36	Other (specify):*	(6,667)	6,667											36
37	<b>TOTAL Ownership</b>	<b>(162,543)</b>	<b>106,334</b>	<b>17,500</b>									<b>(38,709)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(3,578)					(581)						(4,159)	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>(3,578)</b>					<b>(581)</b>						<b>(4,159)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(222,705)</b>	<b>106,673</b>	<b>(237,099)</b>	<b>96,479</b>	<b>20,274</b>	<b>(923)</b>						<b>(237,301)</b>	<b>45</b>

Facility Name & ID Number Sterling Pavilion

# 0040436

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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		Sterling Building, LLC		Bldg. Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 721,244	Sterling Building, LLC		\$	(721,244)	1
2	V	32 Interest Expense - Cap. Lease		Sterling Building, LLC		653,878	653,878	2
3	V	30 Depreciation Expense		Sterling Building, LLC		161,762	161,762	3
4	V	36 Amortization Expense		Sterling Building, LLC		6,667	6,667	4
5	V	21 Franchise Tax		Sterling Building, LLC		250	250	5
6	V	32 Interest Expense - MB Loan		Sterling Building, LLC		5,271	5,271	6
7	V	21 Bank Charges		Sterling Building, LLC		89	89	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 721,244			\$ 827,917	\$ * 106,673	14

\* 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: 01/01/06

Ending: 12/31/06

**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%	\$ 909	909	15
16	V	6 REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.		4,419	4,419	16
17	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.		875	875	17
18	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.		577	577	18
19	V	21 CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.		39,646	39,646	19
20	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.		154	154	20
21	V	25 AUTO EXP.		DYNAMIC HEALTH CARE CONS.		883	883	21
22	V	26 INSURANCE		DYNAMIC HEALTH CARE CONS.		3,443	3,443	22
23	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.		7,403	7,403	23
24	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.		7,475	7,475	24
25	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.		2,188	2,188	25
26	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.		2,791	2,791	26
27	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.		5,046	5,046	27
28	V							28
29	V	19 BOOKKEEPING SERVICES	309,365	DYNAMIC HEALTH CARE CONS.			(309,365)	29
30	V	19 ACCOUNTING	3,543	DYNAMIC HEALTH CARE CONS.			(3,543)	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		\$ 312,908			\$ 75,809	\$ * (237,099)	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%	\$ 5,374	5,374	15
16	V	10 DON SALARY - NON-OWNER		DYNAMIC HEALTH CARE CONS.				16
17	V	17 ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.		14,618	14,618	17
18	V	17 ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.		16,632	16,632	18
19	V	17 ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.		10,399	10,399	19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.				20
21	V	17 ADMIN. CMP. - S. KOPLIN		DYNAMIC HEALTH CARE CONS.		9,579	9,579	21
22	V	17 ADMIN. CMP. - D. MAGAFAS		DYNAMIC HEALTH CARE CONS.		10,326	10,326	22
23	V	17 ADMIN. CMP. - S. LEVY		DYNAMIC HEALTH CARE CONS.		13,971	13,971	23
24	V	17 ADMIN. CMP. - HOWARD ALTER		DYNAMIC HEALTH CARE CONS.				24
25	V	17 ADMIN. CMP. - NON-OWNER		DYNAMIC HEALTH CARE CONS.		9,453	9,453	25
26	V	21 CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.		6,127	6,127	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		\$			\$ 96,479	\$ * 96,479	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	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 528	528	15
16	V	15 EMP. BEN - DON SALARY- NON OWNER		DYNAMIC HEALTH CARE CONS.				16
17	V	27 EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.		1,045	1,045	17
18	V	27 EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.		1,650	1,650	18
19	V	27 EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.		7,367	7,367	19
20	V	27 EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.				20
21	V	27 EMP. BEN.- S. KOPLIN		DYNAMIC HEALTH CARE CONS.		3,034	3,034	21
22	V	27 EMP. BEN.- D. MAGAFAS		DYNAMIC HEALTH CARE CONS.		1,820	1,820	22
23	V	27 EMP. BEN.- S. LEVY		DYNAMIC HEALTH CARE CONS.		1,434	1,434	23
24	V	27 EMP. BEN.- HOWARD ALTER		DYNAMIC HEALTH CARE CONS.				24
25	V	27 EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.		2,148	2,148	25
26	V	27 EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.		1,248	1,248	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		\$			\$ 20,274	\$ * 20,274	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	10	MEDICAL SUPPLIES	3,049	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	2,707	\$	(342)	15
16	V	39	ANCILLARY EXPENSE	5,175	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	4,594		(581)	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			\$ 8,224			\$ 7,301	\$ *	(923)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	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

**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.

**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:

01/01/06

Ending:

12/31/06

## 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	3.91	9.78%	Allocated	\$ 16,632	17-7	1
2	Marshall Mauer	Owner	Administrative	8.26%	See Attached	3.44	6.88%	Allocated	14,618	17-7	2
3	Sue Koplín	Owner	Administrative	0.39%	See Attached	5.39	13.48%	Allocated	9,579	17-7	3
4	Diana Magafas	Owner	Administrative	0.39%	See Attached	4.40	9.78%	Allocated	10,326	17-7	4
5	Dennis Nehmer	Owner	Maintenance	0.39%	See Attached	3.91	9.78%	Allocated	5,374	6-7	5
6	Sharon Aaron	Owner	Clerical	0.39%	See Attached	3.44	8.60%	Allocated	6,127	21-7	6
7	Fred Aaron	Owner	Administrative	23.80%	See Attached	8.50	18.09%	Alloc./Sal	20,399	17-1,17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 83,055		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:  01/01/06  Ending:  12/31/06

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:

01/01/06

Ending: 12/31/06

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	408,951	12	\$ 10,593	\$ 35,094	\$ 909	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	408,951	12	51,500	35,094	4,419	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	408,951	12	10,199	35,094	875	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	408,951	12	6,724	35,094	577	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	408,951	12	461,999	356,210	39,646	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	408,951	12	1,791	35,094	154	6
7	25	AUTO EXP.	PATIENT DAYS	408,951	12	10,284	35,094	883	7
8	26	INSURANCE	PATIENT DAYS	408,951	12	40,124	35,094	3,443	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	408,951	12	86,265	35,094	7,403	9
10	30	DEPRECIATION	PATIENT DAYS	408,951	12	87,103	35,094	7,475	10
11	32	INTEREST	PATIENT DAYS	408,951	12	25,499	35,094	2,188	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	408,951	12	32,525	35,094	2,791	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	408,951	12	58,806	35,094	5,046	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					\$ 883,412	\$ 356,210	\$ 75,809	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

# 0040436

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	54,933	54,933	4	5,374	1
2	10	DON SALARY - NON-OWNWER	WGHTD. AVG. HOURS	40	1	74,145	74,145			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	170,000	170,000	3	14,618	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	170,000	170,000	4	16,632	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	47	6	57,500	57,500	9	10,399	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	27,199	27,199			6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	7	71,067	71,067	5	9,579	7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	105,603	105,603	4	10,326	8
9	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	11	162,480	162,480	4	13,971	9
10	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			10
11	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	9	96,679	96,679	4	9,453	11
12	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	71,245	71,245	3	6,127	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					\$ 1,072,851	\$ 1,072,853		\$ 96,479	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

# 0040436

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	5,392	4	528	1
2	15	EMP. BEN - DON SALARY- NON	WGHTD. AVG. HOURS	40	1	15,214			2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	12,149	3	1,045	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	16,867	4	1,650	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	47	6	40,734	9	7,367	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	31,524			6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	7	22,507	5	3,034	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	18,613	4	1,820	8
9	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	11	16,678	4	1,434	9
10	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,101			10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	9	21,972	4	2,148	11
12	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	14,514	3	1,248	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					\$ 217,265	\$	\$ 20,274	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

# 0040436

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	10	MEDICAL SUPPLIES	DIRECT ALLOCATION					2,707	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION					4,594	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				\$	\$		\$ 7,301	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number  Sterling Pavilion

#  0040436  Report Period Beginning:  01/01/06  Ending:  12/31/06

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:  01/01/06  Ending:  12/31/06

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:  01/01/06  Ending:  12/31/06

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:  01/01/06  Ending:  12/31/06

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:  01/01/06  Ending:  12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	<a href="#">Sterling Building, LLC</a>	X		<a href="#">Capitalized Leases</a>			\$	\$ 6,458,949		\$ 653,878	1									
2											2									
3											3									
4											4									
5	<a href="#">See Supplemental Schedule</a>										5									
<b>Working Capital</b>																				
6	<a href="#">MB Financial Bank</a>		X	<a href="#">Line of Credit</a>				493,378		45,200	6									
7				<a href="#">Insurance Financing</a>						1,474	7									
8	<a href="#">See Supplemental Schedule</a>							121,000		5,277	8									
9	<b>TOTAL Facility Related</b>						\$	\$ 7,073,327		\$ 705,829	9									
<b>B. Non-Facility Related*</b>																				
10	<a href="#">Interest Income</a>		X							(23,898)	10									
11	<a href="#">Allocated Dynamic Healthcare</a>									2,188	11									
12	<a href="#">PPA-Interest Income</a>									(2,913)	12									
13	<a href="#">See Supplemental Schedule</a>										13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		(24,623)	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 7,073,327		\$ 681,206	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:

01/01/06

Ending:

12/31/06

**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										
										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	MB Financial Bank		X	Loan Payable			\$	121,000		\$	5,271	8							
9	Miscellaneous Interest		X								6	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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.

**2005 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 2005 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 2005.

(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>28,904.22</u>	\$ <u>28,904.22</u>
2. <u>11-16-402-013</u>	<u>Long Term Care Property</u>	\$ <u>1,289.34</u>	\$ <u>1,289.34</u>
3. <u>10-23-404-059-0000</u>	<u>Allocated Home Office</u>	\$ <u>31,216.76</u>	\$ <u>2,678.86</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>61,410.32</u>	\$ <u>32,872.42</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

**2000 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 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Sterling Pavilion

# 0040436 Report Period Beginning:

01/01/06 Ending:

12/31/06

**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>Sterling Building LLC</u>			<u>100,000</u>	2
3	<b>TOTALS</b>			\$ <b>148,888</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

# 0040436

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	12,750	9
10	Various			1994	6,356		20	319	319	4,010	10
11	Various			1995	13,538		20	677	677	7,664	11
12	Various			1996	33,635		20	1,681	1,681	17,295	12
13	Various			1997	65,081		20	3,255	3,255	30,656	13
14	Various			1998	86,428		20	4,323	4,323	36,422	14
15	Various			1999	77,777		20	3,858	3,858	29,724	15
16	Various			2000	11,922		20	597	597	3,803	16
17	Various			2001	31,146		20	1,558	1,558	8,556	17
18	Various			2002	99,866		20	9,988	9,988	46,233	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:

01/01/06

Ending:

12/31/06

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		6,052,408	155,190			(155,190)	1,933,409	67
68		38,067	976		1,088	112	14,502	68
69			39,503			(39,503)		69
70		\$ 6,534,947	\$ 195,669		\$ 28,282	\$ (167,387)	\$ 2,145,024	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

# 0040436

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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>		\$ 6,534,947	\$ 195,669		\$ 28,282	\$ (167,387)	\$ 2,145,024	1
2	Doors	2003	5,532		20	553	553	2,121	2
3	Remodel Bathroom	2003	1,418		20	142	142	544	3
4	Bathroom Remodeling	2003	8,563		20	856	856	3,282	4
5	Floor Tile	2003	1,472		20	147	147	564	5
6	Overbed Lights	2003	651		20	65	65	239	6
7	Window Treatments	2003	3,269		20	327	327	1,199	7
8	Rewire Fire Panel	2003	2,132		20	213	213	746	8
9	Door Contacts For Wanderguard Sys	2003	2,942		20	294	294	956	9
10	2 Entrance & Doors	2003	10,605		20	1,061	1,061	3,447	10
11	Variance On 2001 Asset	2003	(2,085)		20	(209)	(209)	(834)	11
12	Condensor Repairs	2003	505		20	51	51	177	12
13	Generator	2003	833		20	83	83	257	13
14	Heating Repairs	2003	1,670		20	167	167	515	14
15	Heating Repairs	2003	2,431		20	243	243	750	15
16	Remodel Bathroom	2004	2,794		20	279	279	838	16
17	Remodel Bathroom	2004	4,713		20	471	471	1,375	17
18	Remodel Bathroom	2004	4,310		20	431	431	1,257	18
19	Tile For Bathroom Remodel	2004	1,155		20	116	116	347	19
20	Mixing Valve For Water System	2004	964		20	96	96	265	20
21	Black Top Entrance	2004	4,700		20	470	470	1,293	21
22	2 Hot Water Heaters	2004	8,691		20	869	869	2,100	22
23	Condensing Unit	2004	4,903		20	490	490	1,185	23
24	A/C & Hot Water Heater	2004	4,111		20	411	411	993	24
25	Parts Fro Install Of Hot Water Heaters	2004	1,302		20	130	130	315	25
26	Parts For Install Of Hot Water Heaters	2004	1,452		20	145	145	339	26
27	Generator Board	2004	2,077		20	208	208	450	27
28	Hosp. Inc. Tile	2004	1,112		20	111	111	241	28
29	Refrigerator - Walk In Freezer	2004	4,500		20	450	450	938	29
30	Motor, Thermostats, Capcators, Blower Motors	2004	1,515		20	151	151	454	30
31	12 Overbed Lights With Pull Chain	2004	1,191		20	119	119	328	31
32	12 Overbed Lights With Pull Chain	2004	1,131		20	113	113	302	32
33	Alarm - Tone Generator	2004	594		20	59	59	153	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,626,100	\$ 195,669		\$ 37,394	\$ (158,275)	\$ 2,172,160	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

# 0040436

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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>		\$ 6,626,100	\$ 195,669		\$ 37,394	\$ (158,275)	\$ 2,172,160	1
2	Leak Repair And Control Valve	2004	703		20	70	70	182	2
3	Motor	2004	952		20	95	95	246	3
4	10 Thermostats	2004	695		20	69	69	156	4
5	Overhead Light	2005	1,339		20	134	134	245	5
6	Install Fire Alarm System	2005	1,596		20	228	228	399	6
7	Water Line Replacement	2005	1,175		20	117	117	186	7
8	Concrete For Sidewalk	2005	518		20	52	52	82	8
9	Concrete For Sidewalk	2005	259		20	17	17	27	9
10	Concrete For Sidewalk	2005	239		20	16	16	24	10
11	Fire Alarm Door Magnetic Lock	2005	1,899		20	271	271	407	11
12	Fire Alarm Door Contacts	2005	892		20	127	127	191	12
13	Replaced Water Service	2005	1,904		20	190	190	270	13
14	Air Conditioners	2005	2,325		20	465	465	659	14
15	Bathroom Remodeling	2005	3,563		20	356	356	445	15
16	Bathroom Remodeling	2005	1,188		20	119	119	148	16
17	Overbed Light	2005	1,448		20	145	145	181	17
18	Installation Of Video Equipment	2005	4,853		20	693	693	809	18
19	Hvac Repairs	2005	4,147		20	207	207	294	19
20	Overbed Lights	2006	1,580		20	158	158	158	20
21	Wall Replacement Kitchen	2006	4,225		20	387	387	387	21
22	Air Conditioners	2006	1,165		20	117	117	117	22
23	Bathroom Tile	2006	937		20	47	47	47	23
24	4 Compressors	2006	1,538		20	77	77	77	24
25	Overbed Lights	2006	1,939		20	48	48	48	25
26	Cornell Door Fire Alarm	2006	4,107		20	98	98	98	26
27	Smoke Detectors	2006	3,510		20	42	42	42	27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	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:

01/01/06

Ending:

12/31/06

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		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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)		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	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:

01/01/06

Ending:

12/31/06

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		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	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:

01/01/06

Ending:

12/31/06

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	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085		1
2									2
3									3
4									4
5									5
6									6
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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)	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085		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:

01/01/06

Ending:

12/31/06

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	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085		1
2									2
3									3
4									4
5									5
6									6
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11									11
12									12
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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)	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 12G, Carried Forward	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	1	
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	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:

01/01/06

Ending:

12/31/06

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		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	1
2									2
3									3
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6									6
7									7
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9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	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:

01/01/06

Ending:

12/31/06

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	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085		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:

01/01/06

Ending:

12/31/06

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		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	1
2								2
3								3
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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)	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	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:

01/01/06

Ending:

12/31/06

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 12K, Carried Forward		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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)		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	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:

01/01/06

Ending:

12/31/06

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 12L, Carried Forward	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085		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:

01/01/06

Ending:

12/31/06

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 12M, Carried Forward		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	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:

01/01/06

Ending:

12/31/06

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 12N, Carried Forward	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085		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:

01/01/06

Ending:

12/31/06

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 12O, Carried Forward		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	1
2									2
3									3
4									4
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6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	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 12P, Carried Forward	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	1	
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,674,796	\$ 195,669		\$ 41,739	\$ (153,930)	\$ 2,178,085	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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1994	1974	\$ 6,052,408	\$ 155,190	35	\$	\$ (155,190)	\$ 1,933,409	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)	\$	1,933,409	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

**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 Dynamic Healthcare		1993	1993	\$ 38,067	\$ 976	35	\$ 1,088	\$ 112	\$ 14,502	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

# 0040436

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
		38,067	976		1,088	112	14,502	

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: 01/01/06 Ending: 12/31/06

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	\$ 331,769	\$ 60	\$ 34,759	\$ 34,699	10	\$ 229,495	71
72	Current Year Purchases	405,455	4,914	3,894	(1,020)	10	3,894	72
73	Fully Depreciated Assets	50,437		61	61	10	50,437	73
74								74
75	TOTALS	\$ 787,661	\$ 4,974	\$ 38,714	\$ 33,740		\$ 283,826	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	Allocated Auto	2005	14,797	1,525	1,993	468	5	7,821	77
78										78
79										79
80	TOTALS			\$ 60,238	\$ 1,525	\$ 1,993	\$ 468		\$ 53,262	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)	\$ 7,671,583	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 202,168	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 82,446	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (119,722)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,515,173	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	\$ 12,843	86
87	Land - 2004	4,235			87
88					88
89					89
90					90
91	TOTALS	\$ 260,543	\$ 6,572	\$ 12,843	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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 7,984 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 type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 46,498		\$	\$		\$ 46,498	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,718			3,718	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	39,224					39,224	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				83,799		83,799	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>						16,765		16,765	13
14	<b>TOTAL</b>			\$ 85,722		\$ 3,718	\$ 100,564		\$ 190,004	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: 01/01/06

Ending:

12/31/06

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ 2,319	\$ 2,482	1
2	Cash-Patient Deposits	37,526	37,526	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	687,086	687,086	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,540	44,540	6
7	Other Prepaid Expenses	4,585	4,585	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify): <u>See Attached Schedule</u>	37,696	49,796	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,013,752	\$ 1,026,015	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	501,255	501,255	15
16	Equipment, at Historical Cost	444,253	807,253	16
17	Accumulated Depreciation (book methods)	(509,955)	(2,846,618)	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>	229,900	44,554	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 714,340	\$ 4,968,282	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,728,092	\$ 5,994,297	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 258,658	\$ 258,658	26
27	Officer's Accounts Payable	62,500	62,500	27
28	Accounts Payable-Patient Deposits	37,526	37,526	28
29	Short-Term Notes Payable		121,000	29
30	Accrued Salaries Payable	250,086	250,086	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,381	1,381	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,000	31,000	32
33	Accrued Interest Payable	854	854	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,841	9,841	35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	4,100	37,431	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 655,946	\$ 810,277	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	493,378	493,378	39
40	Mortgage Payable		6,458,949	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>	\$ 493,378	\$ 6,952,327	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,149,324	\$ 7,762,604	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 578,768	\$ (1,768,307)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,728,092	\$ 5,994,297	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 646,727	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 646,727	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(239,879)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	171,920	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (67,959)</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 578,768</b>	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion# 0040436Report Period Beginning: 01/01/06Ending: 12/31/06**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	\$ 4,272,350	1
2	Discounts and Allowances for all Levels	(657,594)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,614,756	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	531,280	6
7	Oxygen	4,130	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 535,410	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	126,073	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,085	19
20	Radiology and X-Ray	5,834	20
21	Other Medical Services	26,980	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 166,972	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	26,811	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 26,811	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See Supplemental Schedule</a>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,343,949	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	814,786	31
32	Health Care	1,718,206	32
33	General Administration	951,254	33
<b>B. Capital Expense</b>			
34	Ownership	843,330	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	190,004	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>	\$ 4,583,828	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(239,879)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (239,879)	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:

01/01/06

Ending:

12/31/06

**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
2	Assistant Director of Nursing	3,104	88,822	27.45	2
3	Registered Nurses	1,595	34,148	19.72	3
4	Licensed Practical Nurses	25,117	530,051	19.62	4
5	CNAs & Orderlies	65,315	743,919	11.06	5
6	CNA Trainees				6
7	Licensed Therapist	1,552	85,722	55.23	7
8	Rehab/Therapy Aides	4,693	51,049	10.17	8
9	Activity Director	3,883	47,226	11.15	9
10	Activity Assistants	7,574	59,327	7.44	10
11	Social Service Workers	3,836	49,472	11.97	11
12	Dietician				12
13	Food Service Supervisor	1,894	33,636	16.09	13
14	Head Cook				14
15	Cook Helpers/Assistants	17,877	140,833	7.59	15
16	Dishwashers				16
17	Maintenance Workers	3,970	59,879	14.17	17
18	Housekeepers	13,411	116,124	8.09	18
19	Laundry	6,058	49,862	7.61	19
20	Administrator	1,998	92,112	42.29	20
21	Assistant Administrator				21
22	Other Administrative	416	10,000	24.04	22
23	Office Manager				23
24	Clerical	2,406	28,051	10.94	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	1,878	22,751	9.56	31
32	Other Health Care(specify)				32
33	Other(specify) <u>See Supplemental</u>	2,311	19,350	8.19	33
34	TOTAL (lines 1 - 33)	168,888	2,262,334 *	\$ 12.72	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	142	\$ 6,792	01-03 35
36	Medical Director	51	2,520	09-03 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	136	5,440	10-03 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	1	125	10a-03 43
44	Activity Consultant			44
45	Social Service Consultant	140	8,148	12-03 45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	470	\$ 23,025	49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Sterling Pavilion

Report Period Beginning: 01/01/06 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 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 - \$4,635
- (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. \$ 2,585 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. \$ N/A 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**