



Facility Name & ID Number Hickory Nursing Pavilion

# 0032029 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>34</u>	Skilled (SNF)	<u>34</u>	<u>12,444</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>40</u>	Intermediate (ICF)	<u>40</u>	<u>14,640</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,084</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>5,228</u>	<u>6</u>	<u>1,324</u>	<u>6,558</u>	8
9	SNF/PED					9
10	ICF	<u>16,964</u>	<u>2</u>	<u>6</u>	<u>16,972</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,192</u>	<u>8</u>	<u>1,330</u>	<u>23,530</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.88%

D. How many bed-hold days during this year were paid by the Department? 19 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 03/01/1987

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 03/01/1987 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 28 and days of care provided 1,324

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	154,700	26,384	6,600	187,684		187,684		187,684		1
2	Food Purchase		117,820		117,820	(24,452)	93,368	(0)	93,367		2
3	Housekeeping	70,623	30,671		101,294		101,294		101,294		3
4	Laundry	42,306	9,205		51,511		51,511		51,511		4
5	Heat and Other Utilities			73,982	73,982		73,982	(192)	73,790		5
6	Maintenance	30,687	7,939	42,514	81,140		81,140	5,624	86,764		6
7	Other (specify):*							296	296		7
8	<b>TOTAL General Services</b>	<b>298,316</b>	<b>192,019</b>	<b>123,096</b>	<b>613,431</b>	<b>(24,452)</b>	<b>588,979</b>	<b>5,728</b>	<b>594,706</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	844,972	29,015	20,279	894,266		894,266		894,266		10
10a	Therapy	29,205		542	29,747		29,747		29,747		10a
11	Activities	58,077	1,868	905	60,850		60,850		60,850		11
12	Social Services	46,908		3,182	50,090		50,090		50,090		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>979,162</b>	<b>30,883</b>	<b>30,908</b>	<b>1,040,953</b>		<b>1,040,953</b>		<b>1,040,953</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	81,977		149,400	231,377		231,377	(77,118)	154,259		17
18	Directors Fees										18
19	Professional Services			33,965	33,965	(5,495)	28,470	137	28,606		19
20	Dues, Fees, Subscriptions & Promotions			31,184	31,184		31,184	(12,750)	18,434		20
21	Clerical & General Office Expenses	26,350	20,469	28,141	74,960		74,960	6,792	81,752		21
22	Employee Benefits & Payroll Taxes			233,233	233,233	24,452	257,685		257,685		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,030	1,030		1,030	463	1,493		24
25	Other Admin. Staff Transportation			1,968	1,968		1,968	1,487	3,455		25
26	Insurance-Prop.Liab.Malpractice			45,335	45,335		45,335	788	46,123		26
27	Other (specify):*							17,528	17,528		27
28	<b>TOTAL General Administration</b>	<b>108,327</b>	<b>20,469</b>	<b>524,256</b>	<b>653,052</b>	<b>18,957</b>	<b>672,009</b>	<b>(62,673)</b>	<b>609,336</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,385,805</b>	<b>243,371</b>	<b>678,260</b>	<b>2,307,436</b>	<b>(5,495)</b>	<b>2,301,941</b>	<b>(56,946)</b>	<b>2,244,995</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 Hickory Nursing Pavilion #0032029 Report Period Beginning: 01/01/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			13,667	13,667		13,667	92,077	105,744		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							3,292	3,292		32
33	Real Estate Taxes			120,156	120,156	5,495	125,651	2,185	127,836		33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)			34
35	Rent-Equipment & Vehicles			784	784		784	3,836	4,620		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			314,607	314,607	5,495	320,102	(78,610)	241,492		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		30,604	77,969	108,573		108,573		108,573		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			40,626	40,626		40,626		40,626		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		30,604	118,595	149,199		149,199		149,199		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,385,805	273,975	1,111,462	2,771,242	(0)	2,771,242	(135,556)	2,635,686		45

**THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	54,547	30		9
10	Interest and Other Investment Income	(1,803)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(0)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,535)	21		24
25	Fund Raising, Advertising and Promotional	(538)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(22,032)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 17,638		\$	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)	(153,194)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (153,194)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (135,556)		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						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

Hickory Nursing Pavilion

ID# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Expense	\$ (9,196)	20	1
2	Cable TV	(981)	05	2
3	COPE Dues	(3,017)	20	3
4	Replacement Tax	(4,848)	21	4
5	Building Company- Accounting Fees	(975)	19	5
6	Building Company- Replacement Tax	(608)	21	6
7	Building Company- Amortization	(1,270)	36	7
8	Prior Year Legal Expense	(823)	19	8
9	Additional Seminar Expense	285	24	9
10	Non-Allowable Legal	(600)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(22,032)		49

Hickory Nursing Pavilion

ID# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES	Amount	Reference	Sch. V Line
50	\$		1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning:

01/01/08

Ending:

12/31/08

## 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	(0)											(0)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(981)		789									(192)	5
6	Maintenance			2,950	2,674								5,624	6
7	Other (specify):*				296								296	7
8	<b>TOTAL General Services</b>	<b>(982)</b>		<b>3,739</b>	<b>2,970</b>								<b>5,728</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(137,118)	60,000								(77,118)	17
18	Directors Fees													18
19	Professional Services	(2,398)	975	1,397		162							137	19
20	Fees, Subscriptions & Promotions	(12,750)											(12,750)	20
21	Clerical & General Office Expenses	(17,991)	608	24,175									6,792	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	285		178									463	24
25	Other Admin. Staff Transportation			1,487									1,487	25
26	Insurance-Prop.Liab.Malpractice			661		127							788	26
27	Other (specify):*			12,987	4,541								17,528	27
28	<b>TOTAL General Administration</b>	<b>(32,854)</b>	<b>1,583</b>	<b>(96,233)</b>	<b>64,541</b>	<b>289</b>							<b>(62,673)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(33,836)</b>	<b>1,583</b>	<b>(92,493)</b>	<b>67,511</b>	<b>289</b>							<b>(56,946)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning:

01/01/08 Ending:

Summary B

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
30	Depreciation	54,547	35,397	663		1,469							92,077	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,803)	2,697	1		2,397							3,292	32
33	Real Estate Taxes					2,185							2,185	33
34	Rent-Facility & Grounds		(180,000)	7,364		(7,364)							(180,000)	34
35	Rent-Equipment & Vehicles			3,836									3,836	35
36	Other (specify):*	(1,270)	1,270											36
37	<b>TOTAL Ownership</b>	<b>51,474</b>	<b>(140,636)</b>	<b>11,864</b>		<b>(1,313)</b>							<b>(78,610)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>17,638</b>	<b>(139,053)</b>	<b>(80,629)</b>	<b>67,511</b>	<b>(1,024)</b>							<b>(135,556)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		Hickory Healthcare Associates		Building Co.
				See Attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	\$ 180,000	Hickory Healthcare Associates	100.00%	\$	\$ (180,000)	1
2	V	32 Interest Income	290	Hickory Healthcare Associates			(290)	2
3	V	19 Accounting Fees		Hickory Healthcare Associates		975	975	3
4	V	32 Mortgage Interest		Hickory Healthcare Associates		2,987	2,987	4
5	V	30 Depreciation		Hickory Healthcare Associates		35,397	35,397	5
6	V	36 Amortization		Hickory Healthcare Associates		1,270	1,270	6
7	V	21 Replacement Tax		Hickory Healthcare Associates		608	608	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 180,290			\$ 41,237	\$ * (139,053)	14

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

Facility Name & ID Number Hickory Nursing Pavilion# 0032029Report Period Beginning: 01/01/08Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	STAYCARE MANAGEMENT, LTD.	100.00%	\$ 789	\$ 789	15
16	V	6 REPAIRS AND MAINT.				2,950	2,950	16
17	V	17 ADMIN. SAL.-NON OWNER				12,282	12,282	17
18	V	19 PROFESSIONAL FEES				1,397	1,397	18
19	V	20 DUES, SUBSCRIPTIONS						19
20	V	21 CLERICAL & GENERAL				24,175	24,175	20
21	V	24 SEMINARS				178	178	21
22	V	25 ADMIN. STAFF TRAVEL				1,487	1,487	22
23	V	26 INSURANCE				661	661	23
24	V	27 EMPLOYEE BENEFITS				12,987	12,987	24
25	V	30 DEPRECIATION				663	663	25
26	V	32 INTEREST				1	1	26
27	V	34 BUILDING RENT				7,364	7,364	27
28	V	35 EQUIPMENT RENTAL				3,836	3,836	28
29	V							29
30	V	17 MANAGEMENT FEES	149,400				(149,400)	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		\$ 149,400			\$ 68,771	\$ * (80,629)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$	\$	15
16	V	6	MAINT. COMP. - NON-OWNER				2,674	2,674	16
17	V	7	EMP. BEN. - S. WEBSTER						17
18	V	7	EMP. BEN. - MAINT. NON-OWNER				296	296	18
19	V	17	ADMIN. COMP - H. WENGROW				45,000	45,000	19
20	V	17	ADMIN. COMP - J. WEBSTER				15,000	15,000	20
21	V	27	EMP. BEN. - H. WENGROW				3,417	3,417	21
22	V	27	EMP. BEN. - J. WEBSTER				1,124	1,124	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		\$				\$ 67,511	\$ * 67,511	39

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

Facility Name & ID Number Hickory Nursing Pavilion# 0032029Report Period Beginning: 01/01/08Ending: 12/31/08

## 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 REPAIRS & MAINTENANCE	\$	DOUBLE YOU REALTY, LLC	100.00%	\$		15
16	V	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		162	162	16
17	V	21 OFFICE EXPENSE		DOUBLE YOU REALTY, LLC				17
18	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		127	127	18
19	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		1,469	1,469	19
20	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		2,397	2,397	20
21	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		2,185	2,185	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	7,364	DOUBLE YOU REALTY, LLC			(7,364)	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		\$ 7,364			\$ 6,340	\$ * (1,024)	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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.

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/08 Ending: 12/31/08

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeff Webster	Owner	Administrative	14.19%	See Attached	5	7.69%	Salary Alloc	\$ 15,000	17-7	1
2	Howard Wengrow	Owner	Administrative	14.19%	See Attached	15	23.08%	Salary Alloc	45,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,000		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	231,969	6	\$ 7,781	\$ 23,530	\$ 789	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	231,969	6	29,086	23,530	2,950	2	
3	17	ADMIN. SAL.-NON OWNER	PATIENT DAYS	231,969	6	121,085	121,085	23,530	12,282	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	231,969	6	13,769	23,530	1,397	4	
5	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	231,969	6		23,530		5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	231,969	6	238,328	209,385	23,530	24,175	6
7	24	SEMINARS	PATIENT DAYS	231,969	6	1,751	23,530	178	7	
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	231,969	6	14,657	23,530	1,487	8	
9	26	INSURANCE	PATIENT DAYS	231,969	6	6,515	23,530	661	9	
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	231,969	6	128,033	23,530	12,987	10	
11	30	DEPRECIATION	PATIENT DAYS	231,969	6	5	23,530	663	11	
12	32	INTEREST	PATIENT DAYS	231,969	6	72,600	23,530	1	12	
13	34	BUILDING RENT	PATIENT DAYS	231,969	6	37,821	23,530	7,364	13	
14	35	EQUIPMENT RENTAL	PATIENT DAYS	231,969	6		23,530	3,836	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 671,431	\$ 330,470	\$ 68,771	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104		1
2	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	6	26,360	26,360	4	2,674
3	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	923			3
4	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,920		4	296
5	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	195,000	195,000	15	45,000
6	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	65	6	195,000	195,000	5	15,000
7	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	14,808		15	3,417
8	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	65	6	14,610		5	1,124
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					\$ 459,725	\$ 426,464		\$ 67,511

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	PATIENT DAYS	231,969	6	\$	23,530	\$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	231,969	6	1,600	23,530	162	2
3	21	OFFICE EXPENSE	PATIENT DAYS	231,969	6		23,530		3
4	26	INSURANCE	PATIENT DAYS	231,969	6	1,253	23,530	127	4
5	30	DEPRECIATION	PATIENT DAYS	231,969	6	14,484	23,530	1,469	5
6	32	INTEREST EXPENSE	PATIENT DAYS	231,969	6	23,628	23,530	2,397	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	231,969	6	21,540	23,530	2,185	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					\$ 62,505	\$	\$ 6,340	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 - SUPPLEMENTAL SCHEDULE**

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

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

\* 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Hickory Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032029

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>23-02-420-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>47,263.36</u>	\$ <u>47,263.36</u>
2. <u>23-02-420-016-0000</u>	<u>Long Term Care Property</u>	\$ <u>47,239.10</u>	\$ <u>47,239.10</u>
3. <u>23-01-302-021-0000</u>	<u>Long Term Care Property</u>	\$ <u>12,367.38</u>	\$ <u>12,367.38</u>
4. <u>23-02-420-015-0000</u>	<u>Long Term Care Property</u>	\$ <u>6,171.13</u>	\$ <u>6,171.13</u>
5. <u>23-02-420-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>3,888.94</u>	\$ <u>3,888.94</u>
6. <u>10-35-329-014-0000</u>	<u>Home Office</u>	\$ <u>26,537.86</u>	\$ <u>2,691.89</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>143,467.77</u>	\$ <u>119,621.80</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Hickory Nursing Pavilion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032029

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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 Hickory Nursing Pavilion

# 0032029 Report Period Beginning:

01/01/08 Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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>16,200</u>	<u>1990</u>	<u>\$ 74,000</u>	<u>1</u>
2	<u>Allocation from Double You</u>		<u>2003</u>	<u>5,072</u>	<u>2</u>
3	<b>TOTALS</b>	<b>16,200</b>		<b>\$ 79,072</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various			1987	22,801		20			19,709	9
10	Various			1988	50,319		20	965	965	44,178	10
11	Various			1989	7,409		20	370	370	6,253	11
12	Various			1990	38,661		20	1,897	1,897	32,917	12
13	Various			1991	6,422		20	321	321	5,195	13
14	Various			1993	30,582		20	1,530	1,530	22,397	14
15	Various			1994	13,592		20	680	680	9,542	15
16	Various			1995	102,781		20	5,139	5,139	67,926	16
17	Various			1996	139,610		20	6,980	6,980	88,388	17
18	Various			1997	54,749		20	2,739	2,739	31,481	18
19	Various			1998	53,522		20	2,676	2,676	28,567	19
20	Various			1999	18,879		20	944	944	8,912	20
21	Various			2000	6,891		20	345	345	2,758	21
22	Various			2001	12,916		20	646	646	4,823	22
23	Various			2002	24,677		20	2,467	2,467	16,843	23
24	Various			2003	68,088		20	3,597	3,597	19,015	24
25	Various			2004	3,360		20	168	168	745	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		1,115,000	35,397		55,750	20,353	906,170	67
68		50,726	1,243		1,355	112	8,031	68
69			13,667			(13,667)		69
70		\$ 1,820,985	\$ 50,307		\$ 88,569	\$ 38,262	\$ 1,323,850	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ <b>1,820,985</b>	\$ <b>50,307</b>		\$ <b>88,569</b>	\$ <b>38,262</b>	\$ <b>1,323,850</b>	1
2	Doorframes	2005	2,800		20	280	280	1,097	2
3	Phone System	2005	4,178		20	418	418	1,462	3
4	Plumbing - Install Piping	2006	3,500		20	350	350	758	4
5	Cubicle Curtains / Draperies	2006	5,798		20	290	290	821	5
6	Plumbing	2007	5,500		20	550	550	1,100	6
7	Installation Of Nurse Call System	2007	6,500		20	650	650	1,083	7
8	Ardmore Fresh Air Em01552 - 2 Boilers	2008	24,350		20	406	406	406	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	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	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
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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	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	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	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
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29									29
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31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12F, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	1
2									2
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12G, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	1
2									2
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30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12H, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	1
2									2
3									3
4									4
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32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12I, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	1
2									2
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28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12J, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	1
2									2
3									3
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12K, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	1
2									2
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28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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 12L, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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 12M, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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 12N, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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 12O, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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		
<b>1</b>	<b>Totals from Page 12P, Carried Forward</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	<b>1</b>
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
<b>34</b>	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,873,611</b>	\$ <b>50,307</b>		\$ <b>91,513</b>	\$ <b>41,206</b>	\$ <b>1,330,577</b>	<b>34</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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	74		1990	1961	\$ 1,115,000	\$ 35,397	20	\$ 55,750	\$ 20,353	\$ 906,170	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
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18											18
19											19
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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				
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56								56				
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62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	<b>TOTAL (lines 4 thru 69)</b>	\$	<b>1,115,000</b>	\$	<b>35,397</b>	\$	<b>55,750</b>	\$	<b>20,353</b>	\$	<b>906,170</b>	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated from Double You		2003	2003	\$ 48,480	\$ 1,243	39	\$ 1,243	\$	\$ 7,407	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Allocation from Staycare Management			2003	2,246	-	20	112	112	624	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0032029**

Report Period Beginning:

**01/01/08**

Ending:

**12/31/08**

**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>	\$	\$ <b>50,726</b>		\$ <b>1,355</b>	\$ <b>112</b>	\$ <b>8,031</b>	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hickory Nursing Pavilion # 0032029 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 125,580	\$ 227	\$ 13,936	\$ 13,709	10	\$ 102,841	71
72	Current Year Purchases	663	663	11	(652)	10	11	72
73	Fully Depreciated Assets	233,871				10	233,871	73
74								74
75	TOTALS	\$ 360,114	\$ 890	\$ 13,947	\$ 13,057		\$ 336,723	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocation from Staycare	Allocation from Staycare	2008	\$ 2,840	\$	\$ 284	\$ 284	5	\$ 2,840	76
77										77
78										78
79										79
80	TOTALS			\$ 2,840	\$	\$ 284	\$ 284		\$ 2,840	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,315,637	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 51,197	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 105,744	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 54,547	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,670,140	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 784 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	Allocation from Staycare		\$	\$ 3,836	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$ 3,836	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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 34,176	\$		\$ 34,176	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,180			3,180	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			40,613			40,613	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				30,604		30,604	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <a href="#">See Supplemental</a>									13
14	<b>TOTAL</b>			\$		\$ 77,969	\$ 30,604		\$ 108,573	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion# 0032029Report Period Beginning: 01/01/08

Ending:

12/31/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(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	\$ 384,105	\$ 440,252	1
2	Cash-Patient Deposits	41,174	41,174	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	856,180	856,180	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,749	57,749	6
7	Other Prepaid Expenses	624	624	7
8	Accounts Receivable (owners or related parties)		14,039	8
9	Other(specify): <u>See Attached Schedule</u>	650	650	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,340,482	\$ 1,410,668	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		74,000	13
14	Buildings, at Historical Cost		1,115,000	14
15	Leasehold Improvements, at Historical Cost	523,899	523,899	15
16	Equipment, at Historical Cost	213,108	324,108	16
17	Accumulated Depreciation (book methods)	(408,510)	(1,161,090)	17
18	Deferred Charges		12,745	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(12,745)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 328,497	\$ 875,917	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,668,979	\$ 2,286,585	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 90,568	\$ 90,568	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,174	41,174	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,164	12,164	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	120,438	120,438	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	400,563	188,885	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 664,907	\$ 453,229	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 664,907	\$ 453,229	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,004,072	\$ 1,833,356	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,668,979	\$ 2,286,585	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 685,468	1
2	Restatements (describe):		2
3	<b>Rounding Adjustment</b>	(6)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 685,462	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	318,610	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 318,610</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 1,004,072</b>	<b>24 *</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hickory Nursing Pavilion# 0032029Report Period Beginning: 01/01/08Ending: 12/31/08**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	\$ 3,052,747	1
2	Discounts and Allowances for all Levels	(155,376)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,897,371</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	164,820	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 164,820</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	12,957	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,679	19
20	Radiology and X-Ray		20
21	Other Medical Services	2,795	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 20,431</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,803	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,803</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	5,427	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 5,427</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,089,852</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	613,431	31
32	Health Care	1,040,953	32
33	General Administration	653,052	33
<b>B. Capital Expense</b>			
34	Ownership	314,607	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	108,573	35
36	Provider Participation Fee	40,626	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,771,242</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>318,610</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 318,610</b>	<b>43</b>

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

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

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

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

Facility Name & ID Number Hickory Nursing Pavilion

# 0032029

Report Period Beginning: 01/01/08

Ending:

12/31/08

**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	1,984	2,120	\$ 78,988	\$ 37.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,453	3,718	89,049	23.95	3
4	Licensed Practical Nurses	7,957	8,972	216,711	24.15	4
5	CNAs & Orderlies	31,219	34,640	326,423	9.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,099	2,493	29,205	11.71	8
9	Activity Director	2,800	3,261	40,673	12.47	9
10	Activity Assistants	1,568	1,706	17,404	10.20	10
11	Social Service Workers	2,981	3,264	46,908	14.37	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,312	35,478	15.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,423	11,784	119,222	10.12	15
16	Dishwashers					16
17	Maintenance Workers	2,576	2,980	30,687	10.30	17
18	Housekeepers	6,475	7,230	70,623	9.77	18
19	Laundry	5,250	5,774	42,306	7.33	19
20	Administrator	1,960	2,160	81,977	37.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,984	2,232	26,350	11.81	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,963	5,917	133,801	22.61	33
34	<b>TOTAL (lines 1 - 33)</b>	<b>89,652</b>	<b>100,563</b>	<b>\$ 1,385,805 *</b>	<b>\$ 13.78</b>	<b>34</b>

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly \$ 6,600	01-03	35
36	Medical Director	Monthly 6,000	09-03	36
37	Medical Records Consultant	Monthly 19,083	10-03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,196	10-03	39
40	Physical Therapy Consultant	15 456	10a-03	40
41	Occupational Therapy Consultant	2 60	10a-03	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	1 26	10a-03	43
44	Activity Consultant	17 905	11-03	44
45	Social Service Consultant	61 3,182	12-03	45
46	Other(specify)			46
47				47
48				48
49	<b>TOTAL (lines 35 - 48)</b>	<b>95 \$ 37,508</b>		<b>49</b>

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Hickory Nursing Pavilion

Report Period Beginning: 01/01/08 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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
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

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC \$7049.33 IAHC \$962.00
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,371 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 40,626  
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. \$ 24,452 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/s  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT