

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: <u>0040436</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Sterling Pavilion</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>105 E. 23Rd Street</u> <u>Sterling</u> <u>61081</u>																									
Number City Zip Code																									
County: <u>Whiteside</u>																									
Telephone Number: <u>(815) 626-4264</u> Fax # <u>(815) 626-3254</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>												
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	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>																								
Date of Initial License for Current Owners: <u>04/01/93</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>121</u>	Skilled (SNF)	<u>121</u>	<u>44,165</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>121</u>	TOTALS	<u>121</u>	<u>44,165</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,645</u>	<u>2,052</u>	<u>5,495</u>	<u>9,192</u>	8
9	SNF/PED					9
10	ICF	<u>14,864</u>	<u>6,346</u>	<u>1,706</u>	<u>22,916</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,509</u>	<u>8,398</u>	<u>7,201</u>	<u>32,108</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.70%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) 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 04/01/1993

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 04/01/1993 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 121 and days of care provided 5,484

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	227,908	13,647	7,993	249,548		249,548		249,548			1
2	Food Purchase		169,263		169,263		169,263	(439)	168,824			2
3	Housekeeping	120,867	29,005		149,872		149,872		149,872			3
4	Laundry	77,709	13,837		91,546		91,546		91,546			4
5	Heat and Other Utilities			135,950	135,950		135,950	857	136,807			5
6	Maintenance	75,120	45,780	63,636	184,536		184,536	18,255	202,791			6
7	Other (specify):*							649	649			7
8	TOTAL General Services	501,604	271,532	207,579	980,715		980,715	19,322	1,000,037			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,616,830	85,761	8,606	1,711,197		1,711,197		1,711,197			10
10a	Therapy		87		87		87		87			10a
11	Activities	125,706	1,516		127,222		127,222		127,222			11
12	Social Services	59,320		4,834	64,154		64,154		64,154			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,801,856	87,364	23,040	1,912,260		1,912,260		1,912,260			16
	C. General Administration											
17	Administrative	134,711			134,711		134,711	103,280	237,991			17
18	Directors Fees											18
19	Professional Services			513,034	513,034	(564)	512,470	(471,610)	40,860			19
20	Dues, Fees, Subscriptions & Promotions			48,004	48,004		48,004	(27,941)	20,063			20
21	Clerical & General Office Expenses	57,819	1,815	214,702	274,336		274,336	(137,671)	136,665			21
22	Employee Benefits & Payroll Taxes			409,702	409,702		409,702		409,702			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,398	3,398		3,398	620	4,018			24
25	Other Admin. Staff Transportation			6,973	6,973		6,973	740	7,713			25
26	Insurance-Prop.Liab.Malpractice			85,032	85,032		85,032	363	85,395			26
27	Other (specify):*							31,069	31,069			27
28	TOTAL General Administration	192,530	1,815	1,280,845	1,475,190	(564)	1,474,626	(501,150)	973,476			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,495,990	360,711	1,511,464	4,368,165	(564)	4,367,601	(481,828)	3,885,773			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			69,411	69,411		69,411	178,210	247,621			30
31	Amortization of Pre-Op. & Org.							0	0			31
32	Interest			52,332	52,332		52,332	435,269	487,601			32
33	Real Estate Taxes			29,029	29,029	564	29,593	5,606	35,199			33
34	Rent-Facility & Grounds			737,556	737,556		737,556	(737,556)				34
35	Rent-Equipment & Vehicles			4,395	4,395		4,395	7,256	11,651			35
36	Other (specify):*											36
37	TOTAL Ownership			892,723	892,723	564	893,287	(111,215)	782,072			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		150,946	743,369	894,315		894,315	(759)	893,556			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,248	66,248		66,248		66,248			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		150,946	809,617	960,563		960,563	(759)	959,804			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,495,990	511,657	3,213,804	6,221,451		6,221,451	(593,803)	5,627,648			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	21,296	30		9
10	Interest and Other Investment Income	(2,905)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(439)	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	(12,195)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(166,000)	21		24
25	Fund Raising, Advertising and Promotional	(20,669)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,839)	20		28
29	Other-Attach Schedule	(87,421)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (272,673)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(321,130)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (321,130)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (593,803)		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 Yes	2 No	3 Amount	4 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	TOTAL (C): (sum of lines 38-46)			\$		47

Sterling Pavilion

ID#	0040436
Report Period Beginning:	01/01/11
Ending:	12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	COPE Dues	\$ (3,012)	20	1
2	Bank Charges	(9,082)	21	2
3	PPA - Fees	(500)	20	3
4	PPA - Lab/Medical Supplies	(759)	39	4
5	PPA - Legal Settlement	(400)	19	5
6	Non-allowable Legal	(8,303)	19	6
7	Building Co. - Amortization	(930)	31	7
8	Building Co. - Professional & Legal Fees	(35,600)	19	8
9	Intercompany Interest	(29,150)	32	9
10	Non-Care Depreciation	(6,572)	30	10
11	Additional R&M	9,962	06	11
12	Capitalized R&M	(2,735)	06	12
13	Non-allowable Travel	(340)	25	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	Total	(87,421)		49

Sterling Pavilion

	ID#	0040436
Report Period Beginning:		01/01/11
Ending:		12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
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
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77				28
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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

Summary A

12/31/11

[illegible]

Summary B

12/31/11

													SUMMARY	
Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)		
Depreciation	14,724	161,762	1,724									178,210	30	
Amortization of Pre-Op. & Org.	(930)	930										0	31	
Interest	(32,055)	464,278	3,046									435,269	32	
Real Estate Taxes		2,400	3,206									5,606	33	
Rent-Facility & Grounds		(737,556)										(737,556)	34	
Rent-Equipment & Vehicles			7,256									7,256	35	
Other (specify):*													36	
TOTAL Ownership	(18,261)	(108,186)	15,232									(111,215)	37	
Ancillary Expense														
E. Special Cost Centers														
Medically Necessary Transportation													38	
Ancillary Service Centers	(759)											(759)	39	
Barber and Beauty Shops													40	
Coffee and Gift Shops													41	
Provider Participation Fee													42	
Other (specify):*													43	
TOTAL Special Cost Centers	(759)											(759)	44	
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(272,673)	(72,586)	(387,066)	138,522								(593,803)	45	

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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	Rental Income	\$ 737,556	Sterling Building LLC	100.00%	\$	(737,556)	1
2	V	33	Real Estate Taxes	26,400	Sterling Building LLC	100.00%	28,800	2,400	2
3	V	32	Interest Expense - MB Loan		Sterling Building LLC	100.00%	6,554	6,554	3
4	V	32	Interest Expense - Cap. Lease		Sterling Building LLC	100.00%	457,724	457,724	4
5	V	30	Depreciation		Sterling Building LLC	100.00%	161,762	161,762	5
6	V	31	Amortization		Sterling Building LLC	100.00%	930	930	6
7	V	19	Professional & Legal Fees		Sterling Building LLC	100.00%	35,600	35,600	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 763,956			\$ 691,370	\$ * (72,586)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 857	\$ 857	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	5,293	5,293	16
17	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	81	81	17
18	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	529	529	18
19	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	579	579	19
20	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	42,803	42,803	20
21	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	620	620	21
22	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	1,080	1,080	22
23	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	363	363	23
24	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	8,933	8,933	24
25	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	1,724	1,724	25
26	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	3,046	3,046	26
27	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	3,206	3,206	27
28	V	19	REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%	564	564	28
29	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	7,256	7,256	29
30	V								30
31	V								31
32	V	19	HOME OFFICE	464,000	DYNAMIC HEALTH CARE CONS.	100.00%		(464,000)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 464,000			\$ 76,934	\$ * (387,066)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 5,735	\$ 5,735	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	16,262	16,262	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	18,430	18,430	17
18	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	13,600	13,600	18
19	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	17	ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	14,060	14,060	21
22	V	17	ADMIN. CMP. - HOWARD ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	17	ADMIN. CMP. - NON-OWNER-V. DAVIS		DYNAMIC HEALTH CARE CONS.	100.00%	4,992	4,992	23
24	V	17	ADMIN. CMP. - NON-OWNER -VAR.		DYNAMIC HEALTH CARE CONS.	100.00%	18,335	18,335	24
25	V	17	ADMIN. CMP. - CFO NON OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	17,601	17,601	25
26	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	6,803	6,803	26
27	V	7	EMP. BEN.- D. NEHMER		DYNAMIC HEALTH CARE CONS.	100.00%	568	568	27
28	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	893	893	28
29	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,034	1,034	29
30	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	8,783	8,783	30
31	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			31
32	V	27	EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			32
33	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	988	988	33
34	V	27	EMP. BEN.- HOWARD ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			34
35	V	27	EMP. BEN.-V. DAVIS		DYNAMIC HEALTH CARE CONS.	100.00%	1,210	1,210	35
36	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	5,783	5,783	36
37	V	27	EMP. BEN.- CFO NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	2,034	2,034	37
38	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,411	1,411	38
39	Total			\$			\$ 138,522	\$ * 138,522	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

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.

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

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.

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	MICHAEL LOVALLO, TRUSTEE FOR EVAN	0.826%	BRIDGEVIEW HEALTH CARE CENTER, LTD.	BRIDGEVIEW	STERLING BUILDING LLC		BUILDING CO.	1
2	ABRAHAM J. STERN	4.959%	GROSSE POINTE MANOR, L.L.C.	NILES	DYNAMIC HEALTH CARE	SKOKIE	BOOKEEPING/CONSULT	2
3	CHANI MAUER	4.240%	OTTAWA PAVILION, LTD.	OTTAWA				3
4	DENNIS NEHMER	0.393%	PARK RIDGE CARE CENTER, LTD.	PARK RIDGE				4
5	DIANIA KUFTA	0.393%	WARREN PARK HEALTH AND LIVING CENTER,LLC	CHICAGO				5
6	ESTHER MARYLES	4.240%	WATERFRONT TERRACE, INC.	CHICAGO				6
7	FRANCES MAUER	8.264%	WILLOW CREST NURSING PAVILION, LTD.	SANDWICH				7
8	FRED L. AARON	23.802%	WINDMILL NURSING PAVILION, LTD.	SOUTH HOLLAND				8
9	JONATHAN BRYAN STERN TRUST DTD	0.826%	WOODBIDGE NURSING PAVILION, LTD.	CHICAGO				9
10	MARSHALL A. MAUER	8.264%	WOODBIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG (S	GALESBURG				10
11	MAURICE I. AARON	22.231%	WOODBIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO (SLI	GENESEO				11
12	MIRIAM LATINIK	4.132%	WOODBIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC (SLF	PONTIAC				12
13	SHARON AARON	0.393%						13
14	SHIMON GOLDSTEIN	4.132%						14
15	SUE KOPLIN HARAMARAS	0.393%						15
16	SUSAN ALTER	4.917%						16
17	SUSAN L. STERN	4.959%						17
18	SYLVIA AARON	1.810%						18
19	TODD ANDREW STERN TRUST DTD 10/31/01	0.826%						19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

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	Marshall Mauer	Owner	Administrative	8.26	See Attached	3.25	6.50%	Alloc. Salary	\$ 16,262	17-7	1
2	Maury Aaron	Owner	Administrative	22.23	See Attached	3.69	7.37%	Alloc. Salary	18,430	17-7	2
3	Sharon Aaron	Owner	Administrative	0.39	See Attached	3.25	8.13%	Alloc. Salary	6,803	21-7	3
4	Dennis Nehmer	Owner	Maintenance	0.39	See Attached	3.69	9.22%	Alloc. Salary	5,735	6-7	4
5	Diania Kufra	Owner	Administrative	0.39	See Attached	4.61	9.22%	Alloc. Salary	14,060	17-7	5
6	Fred Aaron	Owner	Administrative	23.80	See Attached	9	20.00%	Sal/Alloc Sal	43,600	17-1, 17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 104,890		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	PATIENT DAYS	416,329	14	\$ 11,113	\$	32,108	\$ 857	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	416,329	14	68,628	12,499	32,108	5,293	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	416,329	14	1,044		32,108	81	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	416,329	14	6,858		32,108	529	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	416,329	14	7,513		32,108	579	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	416,329	14	555,005	401,070	32,108	42,803	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	416,329	14	8,041		32,108	620	7
8	25	AUTO EXP.	PATIENT DAYS	416,329	14	14,007		32,108	1,080	8
9	26	INSURANCE	PATIENT DAYS	416,329	14	4,707		32,108	363	9
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	416,329	14	115,833		32,108	8,933	10
11	30	DEPRECIATION	PATIENT DAYS	416,329	14	22,348		32,108	1,724	11
12	32	INTEREST	PATIENT DAYS	416,329	14	39,492		32,108	3,046	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	416,329	14	41,569		32,108	3,206	13
14	33	REAL ESTATE TAX PROTEST	PATIENT DAYS	416,329	14	7,315		32,108	564	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	416,329	14	94,081		32,108	7,256	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 997,554	\$ 413,569		\$ 76,934	25

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	8	62,231	62,231	3.69	5,735	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	200,000	200,000	3.25	16,262	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	200,000	200,000	3.69	18,430	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	68,000	68,000	9.00	13,600	4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	121,602	121,602			5
6	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	40	4	74,106	74,106			6
7	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	8	152,525	152,525	4.61	14,060	7
8	17	ADMIN. CMP. - HOWARD ALTI	WGHTD. AVG. HOURS	50	1	12,000	12,000			8
9	17	ADMIN. CMP. - NON-OWNER-V	WGHTD. AVG. HOURS	40	8	74,874	74,874	2.67	4,992	9
10	17	ADMIN. CMP. - NON-OWNER -V	WGHTD. AVG. HOURS	45	8	198,817	198,817	4.15	18,335	10
11	17	ADMIN. CMP. - CFO NON OWN	WGHTD. AVG. HOURS	45	10	216,469	216,469	3.66	17,601	11
12	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	83,751	83,751	3.25	6,803	12
13	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	8	6,161		3.69	568	13
14	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	10,982		3.25	893	14
15	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	11,224		3.69	1,034	15
16	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	43,917		9.00	8,783	16
17	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	44,352				17
18	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	40	4	30,190				18
19	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	8	10,718		4.61	988	19
20	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	50	1	1,101				20
21	27	EMP. BEN.-V. DAVIS	WGHTD. AVG. HOURS	40	8	18,154		2.67	1,210	21
22	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	62,705		4.15	5,783	22
23	27	EMP. BEN.- CFO NON-OWNER	WGHTD. AVG. HOURS	45	10	25,019		3.66	2,034	23
24	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	17,376		3.25	1,411	24
25	TOTALS					\$ 1,746,274	\$ 1,464,375		\$ 138,522	25

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/11 Ending: 12/31/11

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
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/11 Ending: 12/31/11

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
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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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	GMAC Mortgage Payable		X	Mortgage			\$	3,737,356			\$	1	
2	Sterling Building LLC		X	Capitalized Lease				2,075,176			457,724	2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	MB Financial		X	Line of Credit				884,533			22,000	6	
7	MB Financial		X	Insurance Financing							768	7	
8	See Supplemental Schedule							221,753			6,968	8	
9	TOTAL Facility Related						\$	6,918,818			\$	487,461	9
	B. Non-Facility Related*												
10	Interest Income		X								(2,905)	10	
11	Allocated from Dynamic										3,046	11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$				\$	141	14
15	TOTALS (line 9+line14)						\$	6,918,818			\$	487,602	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8	MB Financial		X	Loan Payable			\$		\$ 127,050			\$ 6,554	8
9	Omnicare		X	Note Payable					94,703			414	9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital								221,753			6,968	14
	B. Non-Facility Related*												
15							\$		\$			\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	25,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	31,235	2
3. Under or (over) accrual (line 2 minus line 1).				\$	5,635	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	29,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	564	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	35,199	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	27,272	8		
		2007	27,175	9		
		2008	27,300	10		
		2009	27,761	11		
		2010	28,029	12		
Beginning Accrual Adjusted						
2010 Accrual = \$28,029 x 1.03 = \$29,000 (Rounded)						
Allocated from Dynamic = \$3,206						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMESterling PavilionCOUNTYWhiteside

FACILITY IDPH LICENSE NUMBER0040436

CONTACT PERSON REGARDING THIS REPORTSteve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>11-16-402-001</u>	<u>Long Term Care Property</u>	\$ <u>26,537.04</u>	\$ <u>26,537.04</u>
2. <u>11-16-402-013</u>	<u>Long Term Care Property</u>	\$ <u>1,491.50</u>	\$ <u>1,491.50</u>
3. <u>10-23-404-059-0000</u>	<u>Allocated From Dynamic</u>	\$ <u>36,436.43</u>	\$ <u>2,810.04</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>64,464.97</u></u>	\$ <u><u>30,838.58</u></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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Sterling Pavilion

COUNTY

Whiteside

FACILITY IDPH LICENSE NUMBER

0040436

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

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</u> <u>Applicable to</u> <u>Nursing Home</u>
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,000

B. General Construction Type: Exterior Brick Frame Steel/Concrete Number of Stories 1

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>48,888</u>	<u>1</u>
2	<u>Sterling Building LLC</u>			<u>100,000</u>	<u>2</u>
3	TOTALS			\$ <u>148,888</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5	121			1974	6,052,408	161,762	35	172,926	11,164	2,780,303
6										6
7										7
8										8
	Improvement Type**									
9	Various		1993	18,723		20	936	936		17,429
10	Various		1994	6,356		20	318	318		5,598
11	Various		1995	13,538		20	677	677		11,048
12	Various		1996	33,635		20	1,682	1,682		25,703
13	Various		1997	65,081		20	3,254	3,254		46,924
14	Various		1998	86,428		20	4,321	4,321		58,026
15	Various		1999	77,777		20	3,857	3,857		49,003
16	Various		2000	11,922		20	596	596		6,783
17	Various		2001	31,146		20	1,557	1,557		16,340
18	Various		2002	99,866		20	9,987	9,987		96,169
19	Various		2003	39,938		20	3,994	3,994		33,930
20	Various		2004	53,564		20	5,356	5,356		40,538
21	Various		2005	27,344		20	2,674	2,674		19,404
22	Various		2006	19,001		20	2,227	2,227		12,572
23	Various		2007	20,058		20	1,664	1,664		7,913
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		34,211	877		977	100	17,920	68
69	Financial Statement Depreciation			62,839			(62,839)		69
70	TOTAL (lines 4 thru 69)		\$ 6,690,996	\$ 225,478		\$ 217,002	\$ (8,476)	\$ 3,245,602	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	Totals from Page 12A, Carried Forward		\$ 6,690,996	\$ 225,478		\$ 217,002	\$ (8,476)	\$ 3,245,602	1
2	Remodeled Shower Room	2008	4,389		20	439	439	1,683	2
3	1 Electric Wall Heater	2008	559		20	56	56	214	3
4	Installed New Amplifier	2008	1,341		20	134	134	503	4
5	4 Outdoor Lights	2008	2,179		20	218	218	763	5
6	Heat/Cool Pump	2008	745		20	74	74	261	6
7	Fire/Smoke Dampers	2008	8,900		20	1,780	1,780	6,230	7
8	Fire Alarm System Dampers	2008	1,867		20	373	373	1,276	8
9	Heat/Cool Heat Pumps	2008	726		20	73	73	248	9
10	Generator Repair	2008	4,199		20	420	420	1,365	10
11	Plumbing Improvements	2008	736		20	74	74	227	11
12	Plumbing Improvements	2008	1,125		20	113	113	347	12
13	Plumbing Improvements	2008	470		20	47	47	145	13
14	Reinstall Locks	2009	2,568		20	66	66	151	14
15	Plumbing Repairs	2009	3,154		20	81	81	165	15
16	Hot Water Heater	2009	11,488		20	295	295	601	16
17	3 Fire Doors	2009	12,197		20	313	313	639	17
18	Window Replacement	2010	2,985		20	77	77	137	18
19	Frame Install	2010	2,952		20	76	76	117	19
20	Water System	2011	2,657		20	54	54	54	20
21	Heating System	2011	3,979		20	199	199	199	21
22	Electrical Wiring	2011	2,721		20	136	136	136	22
23	Electrical Wiring And Permanent Setup Of Kiosk Walls	2011	10,544		20	527	527	527	23
24	Electrical Wiring And Permanent Setup Of Kiosk Walls	2011	6,717		20	336	336	336	24
25	Hot Water Pump Repalacement	2011	4,895		20	245	245	245	25
26	Bathroom-Floor, Wall, Ceiling, Faucet	2011	4,255		20	213	213	213	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,789,344	\$ 225,478		\$ 223,419	\$ (2,059)	\$ 3,262,382	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,789,344	\$ 225,478		\$ 223,419	\$ (2,059)	\$ 3,262,382	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,789,344	\$ 225,478		\$ 223,419	\$ (2,059)	\$ 3,262,382	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,789,344	\$ 225,478		\$ 223,419	\$ (2,059)	\$ 3,262,382	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,789,344	\$ 225,478		\$ 223,419	\$ (2,059)	\$ 3,262,382	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,789,344	\$ 225,478		\$ 223,419	\$ (2,059)	\$ 3,262,382	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,789,344	\$ 225,478		\$ 223,419	\$ (2,059)	\$ 3,262,382	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Dynamic	1993	34,211	877	35	977	100	17,920	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								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
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$34,211	\$877		\$977	\$100	\$17,920	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$227,144	\$	\$16,409	\$16,409	10	\$204,507	71
72	Current Year Purchases	42,737		4,166	4,166	10	4,166	72
73	Fully Depreciated Assets	582,186		13	13	10	582,110	73
74								74
75	TOTALS	\$852,067	\$	\$20,588	\$20,588		\$790,784	75

D. Vehicle Costs. (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		BUS	2000	\$45,441	\$	\$		5	\$45,441	76
77		BRUN WHEEL CHAIR LIFT IN	2008	4,985		682	682	5	3,962	77
78		Allocated from Dynamic	2010	17,752	847	2,932	2,085	5	8,378	78
79										79
80	TOTALS			\$68,178	\$847	\$3,614	\$2,767		\$57,781	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$7,858,477	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$226,325	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$247,621	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$21,296	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,110,946	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building 2004 - 2004	\$256,308	\$6,572	\$73,114	86
87	Land 2004 - 2004	4,235			87
88					88
89					89
90					90
91	TOTALS	\$260,543	\$6,572	\$73,114	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

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?
16. Rental Amount for movable equipment: \$ 4,395
- 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	Allocated from Dynamic		\$	\$ 7,256	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 7,256	21

10. Effective dates of current rental agreement:

Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

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

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

(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.)

12345678										
	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	\$		\$ 254,333	\$		\$ 254,333	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			99,417			99,417	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			389,619			389,619	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 prescrpts				139,733		139,733	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						11,213		11,213	13
14	TOTAL			\$		\$ 743,369	\$ 150,946		\$ 894,315	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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$11,603	\$131,626	1
2	Cash-Patient Deposits	91,711	91,711	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	715,960	715,960	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,192	58,192	6
7	Other Prepaid Expenses	6,076	6,076	7
8	Accounts Receivable (owners or related parties)		49,682	8
9	Other(specify): See Attached Schedule	45,064	332,164	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$928,606	\$1,385,411	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		104,235	13
14	Buildings, at Historical Cost		6,308,716	14
15	Leasehold Improvements, at Historical Cost	626,081	626,081	15
16	Equipment, at Historical Cost	539,836	829,722	16
17	Accumulated Depreciation (book methods)	(741,147)	(3,813,506)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,498	6,498	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,498)	(6,498)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	354,034	377,277	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$778,804	\$4,432,525	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$1,707,410	\$5,817,936	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$410,599	\$410,599	26
27	Officer's Accounts Payable	62,500	62,500	27
28	Accounts Payable-Patient Deposits	91,711	91,711	28
29	Short-Term Notes Payable		127,050	29
30	Accrued Salaries Payable	262,515	262,515	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,422	4,422	31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,000	29,000	32
33	Accrued Interest Payable	6,738	6,738	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,395	7,395	35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$874,880	\$1,001,930	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	979,236	979,236	39
40	Mortgage Payable		5,812,532	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		229,900	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$979,236	\$7,021,668	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$1,854,116	\$8,023,598	46
47	TOTAL EQUITY(page 18, line 24)	\$(146,706)	\$(2,205,662)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$1,707,410	\$5,817,936	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (402,257)	1
2	Restatements (describe):		2
3	Rounding Adjustment	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (402,255)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	255,549	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	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 255,549	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (146,706)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,045,206	1
2	Discounts and Allowances for all Levels	(2,079,372)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,965,834	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,172,060	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,172,060	8
	C. Other Operating Revenue		
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	210,201	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,464	19
20	Radiology and X-Ray	4,062	20
21	Other Medical Services	4,202	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 228,929	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,905	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,905	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	107,272	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 107,272	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,477,000	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	980,715	31
32	Health Care	1,912,260	32
33	General Administration	1,475,190	33
	B. Capital Expense		
34	Ownership	892,723	34
	C. Ancillary Expense		
35	Special Cost Centers	894,315	35
36	Provider Participation Fee	66,248	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,221,451	40
41	Income before Income Taxes (line 30 minus line 40)**	255,549	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 255,549	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,005	2,086	\$ 59,632	\$ 28.59	1
2	Assistant Director of Nursing	1,386	1,410	43,308	30.71	2
3	Registered Nurses	8,026	8,181	220,172	26.91	3
4	Licensed Practical Nurses	20,547	21,368	475,348	22.25	4
5	CNAs & Orderlies	67,562	72,377	818,370	11.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,981	2,086	26,780	12.84	9
10	Activity Assistants	9,497	10,506	98,926	9.42	10
11	Social Service Workers	3,678	4,190	59,320	14.16	11
12	Dietician					12
13	Food Service Supervisor	1,861	2,086	39,946	19.15	13
14	Head Cook	4,494	4,884	48,257	9.88	14
15	Cook Helpers/Assistants	13,893	15,400	139,705	9.07	15
16	Dishwashers					16
17	Maintenance Workers	3,977	4,941	75,120	15.20	17
18	Housekeepers	11,381	12,388	120,867	9.76	18
19	Laundry	7,660	8,408	77,709	9.24	19
20	Administrator	1,941	2,246	104,711	46.62	20
21	Assistant Administrator					21
22	Other Administrative	890	890	30,000	33.71	22
23	Office Manager					23
24	Clerical	4,111	4,335	57,819	13.34	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) See Supplemental					33
34	TOTAL (lines 1 - 33)	164,890	177,782	\$ 2,495,990 *	\$ 14.04	34

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	147	\$ 7,993	01-03	35
36	Medical Director	192	9,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	153	6,106	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	81	4,834	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	50	2,500	10-03	47
48					48
49	TOTAL (lines 35 - 48)	623	\$ 31,033		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberSterling Pavilion

0040436

Report Period Beginning:01/01/11

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Ending:12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rhonda Reed	Administrator	0%	\$ 104,711
Fred Aaron	Administrative	23.80%	30,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 134,711

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	\$ 16,292
Personnel Planners, Inc	Unemployment Consulting	1,332
See Attached	Legal	16,486
Health Data Systems Inc	Data Processing	11,324
Dynamic HC Consultants	Bookkeeping	464,000
Casamba	Data Processing	3,600
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 513,034

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 60,140	
Unemployment Compensation Insurance	37,463	
FICA Taxes	189,607	
Employee Health Insurance	116,816	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Other Employee Benefits	5,676	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 409,702

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment	3,704	
Health Care Worker Background Check (Indicate # of checks performed 320)	3,230	
Patient Background Checks		
Advertising & Promotion	24,508	
Dues & Subscriptions	9,783	
Licenses & Fees	2,766	
Allocated from Dynamic	579	
Less: Public Relations Expense	()	
Non-allowable advertising	(20,669)	
Yellow page advertising	(3,839)	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 20,062

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	3,398
Allocated from Dynamic	620
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 4,018

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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?

No
- (2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

ILCLTC \$10,672 ; IL Assoc. of HC \$1,452
- (3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 Years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

1,629

Line

10-2
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

66,248

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

No

Has any meal income been offset against related costs?

Indicate the amount.

\$

N/A
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100% ln 14

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out 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