

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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>01/01/12</u> to <u>12/31/12</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>(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><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(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>	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												
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	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																								
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:																									
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: 01/01/12 Ending: 12/31/12

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 <u>N/A</u>					
	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>44,286</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>44,286</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>460</u>	<u>1,097</u>	<u>5,177</u>	<u>6,734</u>	8
9	SNF/PED					9
10	ICF	<u>14,375</u>	<u>6,026</u>	<u>1,625</u>	<u>22,026</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,835</u>	<u>7,123</u>	<u>6,802</u>	<u>28,760</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.94%

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 5,168

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/12 Ending: 12/31/12
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	229,323	20,894	8,076	258,293		258,293		258,293			1
2	Food Purchase		161,238		161,238		161,238	(399)	160,839			2
3	Housekeeping	127,607	20,868		148,475		148,475		148,475			3
4	Laundry	78,259	15,552		93,811		93,811		93,811			4
5	Heat and Other Utilities			114,430	114,430		114,430	818	115,248			5
6	Maintenance	68,272	60,231	48,676	177,179		177,179	11,914	189,093			6
7	Other (specify):*							660	660			7
8	TOTAL General Services	503,461	278,783	171,182	953,426		953,426	12,993	966,419			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,497,396	73,385	11,685	1,582,466		1,582,466		1,582,466			10
10a	Therapy		2,066		2,066		2,066		2,066			10a
11	Activities	123,584	2,668		126,252		126,252		126,252			11
12	Social Services	58,529		4,371	62,900		62,900		62,900			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,679,509	78,119	25,656	1,783,284		1,783,284		1,783,284			16
	C. General Administration											
17	Administrative	133,155			133,155		133,155	87,711	220,866			17
18	Directors Fees											18
19	Professional Services			499,384	499,384		499,384	(452,851)	46,533			19
20	Dues, Fees, Subscriptions & Promotions			37,993	37,993		37,993	(24,051)	13,942			20
21	Clerical & General Office Expenses	85,029	2,387	266,253	353,669		353,669	(186,355)	167,314			21
22	Employee Benefits & Payroll Taxes			594,885	594,885		594,885		594,885			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,424	4,424		4,424	1,893	6,317			24
25	Other Admin. Staff Transportation			6,779	6,779		6,779	51	6,830			25
26	Insurance-Prop.Liab.Malpractice			72,113	72,113		72,113		72,113			26
27	Other (specify):*							25,951	25,951			27
28	TOTAL General Administration	218,184	2,387	1,481,831	1,702,402		1,702,402	(547,651)	1,154,751			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,401,154	359,289	1,678,669	4,439,112		4,439,112	(534,658)	3,904,454			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			269,531	269,531		269,531	6,170	275,701			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75,604	75,604		75,604	421,451	497,055			32
33	Real Estate Taxes			27,535	27,535		27,535	(301)	27,234			33
34	Rent-Facility & Grounds			737,556	737,556		737,556	(737,556)				34
35	Rent-Equipment & Vehicles			5,760	5,760		5,760	6,777	12,537			35
36	Other (specify):*											36
37	TOTAL Ownership			1,115,986	1,115,986		1,115,986	(303,459)	812,527			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,627	658,135	815,762		815,762	(176)	815,586			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			329,554	329,554		329,554	(119,919)	209,635			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		157,627	987,689	1,145,316		1,145,316	(120,095)	1,025,221			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,401,154	516,916	3,782,344	6,700,414		6,700,414	(958,212)	5,742,202			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	(151,087)	30		9
10	Interest and Other Investment Income	(1,243)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(399)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(136,823)	21		24
25	Fund Raising, Advertising and Promotional	(17,391)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(308,493)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (616,436)		\$	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)	(341,776)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (341,776)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (958,212)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Sterling Pavilion

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (16,195)	21	1
2	Building Co.-Amortization	(930)	31	2
3	Building Co.- Professional & Legal Fees	(35,880)	19	3
4	Building Co.-Licenses & Fees	(250)	20	4
5	Intercompany Interest	(33,525)	32	5
6	Non- Allowable Legal	(7,750)	19	6
7	COPE Dues	(6,170)	20	7
8	Building Co. - Bank Fees	(132)	21	8
9	Non-Care Depreciation	(6,572)	30	9
10	PPA - Legal Fees	(100)	19	10
11	PPA - Various Expenses	(80,894)	21	11
12	PPA - Lab Medicare	(176)	39	12
13	PPA - IL Provider Tax	(119,919)	42	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
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31				31
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34				34
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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	(308,493)		49

Sterling Pavilion

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

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
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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

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 PG6-Supplemental		See PG6-Supplemental		See PG6-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	Rent Income	\$ 737,556			\$	(737,556)	1
2	V	33	Real Estate Taxes	31,749			28,800	(2,949)	2
3	V	32	Interest Expense-MB Loan				4,579	4,579	3
4	V	32	Interest Expenses-Cap. Lease				449,215	449,215	4
5	V	30	Depreciation				161,762	161,762	5
6	V	31	Amortization				930	930	6
7	V	21	Bank Fees				132	132	7
8	V	20	Licenses and Fees				250	250	8
9	V	19	Professional and Legal Fees				35,880	35,880	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 769,305			\$ 681,548	\$ * (87,757)	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%	\$ 818	\$ 818	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	7,030	7,030	16
17	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	151	151	17
18	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	999	999	18
19	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	510	510	19
20	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	41,188	41,188	20
21	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	1,893	1,893	21
22	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	51	51	22
23	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	7,945	7,945	23
24	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	2,067	2,067	24
25	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	2,425	2,425	25
26	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	2,648	2,648	26
27	V	35	AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	6,540	6,540	27
28	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	237	237	28
29	V								29
30	V								30
31	V								31
32	V	19	BOOKEEPPING FEES	446,000	DYNAMIC HEALTH CARE CONS.			(446,000)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 446,000			\$ 74,502	\$ * (371,498)	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%	\$ 4,884	\$ 4,884	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	14,638	14,638	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	16,629	16,629	17
18	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	9,400	9,400	18
19	V	17	ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	17	ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	12,661	12,661	22
23	V	17	ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	17	ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	5,885	5,885	24
25	V	17	ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	15,322	15,322	25
26	V	17	ADMIN. CMP. - CFO (NON-OWNER) .		DYNAMIC HEALTH CARE CONS.	100.00%	13,176	13,176	26
27	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	6,253	6,253	27
28	V	21	CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	116	116	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			\$			\$ 98,964	\$ * 98,964	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 509	\$ 509	15
16	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	794	794	16
17	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,147	1,147	17
18	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	7,237	7,237	18
19	V	27	EMP. BEN.- D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	27	EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	888	888	22
23	V	27	EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	27	EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	1,011	1,011	24
25	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	4,107	4,107	25
26	V	27	EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	1,650	1,650	26
27	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,162	1,162	27
28	V	27	EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	10	10	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			\$			\$ 18,515	\$ * 18,515	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

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

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	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	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

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

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	2.93	5.86%	Alloc. Salary	\$ 14,683	17-7	1
2	Maury Aaron	Owner	Administrative	22.23%	See attached	3.33	6.65%	Alloc. Salary	16,629	17-7	2
3	Sharon Aaron	Owner	Clerical	0.39%	See attached	2.93	7.32%	Alloc. Salary	6,253	21-7	3
4	Dennis Nehmer	Owner	Administrative	0.39%	See attached	3.33	8.33%	Alloc. Salary	4,884	6-7	4
5	Diania Kufra	Owner	Administrative	0.393%	See attached	4.16	8.31%	Alloc. Salary	12,661	17-7	5
6	Fred Aaron	Owner	Administrative	23.80%	See attached	9	20.00%	Sal./Alloc. Salary	39,400	17-1, 17-7	6
7	Esther Maryles	Owner	Clerical	4.24%	See attached	0.21	76.00%	Alloc. Salary	116	116	7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 94,626		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: 01/01/12 Ending: 12/31/12

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

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	413,728	13	\$ 11,773	\$	28,760	\$ 818	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	413,728	13	101,134	34,519	28,760	7,030	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	413,728	13	2,165		28,760	151	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	413,728	13	14,369		28,760	999	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	413,728	13	7,338		28,760	510	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	413,728	13	592,509	421,664	28,760	41,188	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	413,728	13	27,227		28,760	1,893	7
8	25	AUTO EXP.	PATIENT DAYS	413,728	13	736		28,760	51	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	413,728	13	114,290		28,760	7,945	9
10	30	DEPRECIATION	PATIENT DAYS	413,728	13	29,732		28,760	2,067	10
11	32	INTEREST	PATIENT DAYS	413,728	13	34,887		28,760	2,425	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	413,728	13	38,096		28,760	2,648	12
13	35	AUTO RENTAL	PATIENT DAYS	413,728	13	94,085		28,760	6,540	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	413,728	13	3,415		28,760	237	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,071,756	\$ 456,183		\$ 74,502	25

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

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	58,740	58,740	3.33	4,884	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	200,000	200,000	2.93	14,638	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	200,000	200,000	3.33	16,629	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	47,000	47,000	9.00	9,400	4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	52,765	52,765			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	102,086	102,086			6
7	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	4	73,867	73,867			7
8	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	8	152,170	152,170	4.16	12,661	8
9	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000			9
10	17	ADMIN. CMP. - V. DAVIS (NON-	WGHTD. AVG. HOURS	40	8	117,701	117,701	2.00	5,885	10
11	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	8	184,393	184,393	3.74	15,322	11
12	17	ADMIN. CMP. - CFO (NON-OW	WGHTD. AVG. HOURS	45	10	180,028	180,028	3.29	13,176	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	85,386	85,386	2.93	6,253	13
14	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	12	15,265	15,265	0.21	116	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,481,401	\$ 1,481,401		\$ 98,964	25

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

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	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	8	6,127		3.33	509	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	10,847		2.93	794	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	13,801		3.33	1,147	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	36,183		9.00	7,237	4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	4,278				5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,829				6
7	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	4	23,776				7
8	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	8	10,672		4.16	888	8
9	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,076				9
10	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	8	20,219		2.00	1,011	10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	49,423		3.74	4,107	11
12	27	EMP. BEN.- CFO (NON-OWNER	WGHTD. AVG. HOURS	45	10	22,545		3.29	1,650	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	15,870		2.93	1,162	13
14	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	12	1,340		0.21	10	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 253,986	\$		\$ 18,515	25

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

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

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

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

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

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

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

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			\$	3,673,091			\$	1	
2	Sterling Building LLC		X	Capitalized Lease				2,002,475			449,215	2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	MB Financial		X	Line of Credit				960,483			37,455	6	
7	MB Financial		X	Insurance Financing							255	7	
8	See Supplemental Schedule							142,055			8,948	8	
9	TOTAL Facility Related						\$	6,778,104			\$ 495,873	9	
	B. Non-Facility Related*												
10	Interest Income		X								(1,243)	10	
11	Allocated from Dynamic		X								2,425	11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$				\$ 1,182	14	
15	TOTALS (line 9+line14)						\$	6,778,104			\$ 497,055	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			\$		\$ 80,850			\$ 4,579	8
9	Omnicare		X	Note Payable					61,205			4,369	9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital								142,055			8,948	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	31,949	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.)		\$	30,183	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,766)	3	
4. Real Estate Tax accrual used for 2012 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.)		\$		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.		\$	27,234	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	27,175	8	
		2008	27,300	9	
		2009	27,761	10	
		2010	28,029	11	
		2011	27,535	12	
Beginning Accrual Adjusted					
2011 Accrual = \$27,535 x 1.05= \$29,000 (rounded)					
Allocated from Dynamic - \$ 2,590.53					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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

FACILITY NAME	<u>Sterling Pavilion</u>	COUNTY	<u>Whiteside</u>
---------------	--------------------------	--------	------------------

CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-16-402-001</u>	<u>Long Term Care Property</u>	\$ <u>26,061.22</u>	\$ <u>26,061.22</u>
2. <u>11-16-402-013</u>	<u>Long Term Care Property</u>	\$ <u>1,474.08</u>	\$ <u>1,474.08</u>
3. <u>10-23404-059-0000</u>	<u>Allocated from Dynamic</u>	\$ <u>37,266.21</u>	\$ <u>2,590.53</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>64,801.51</u></u>	\$ <u><u>30,125.83</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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

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

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sterling Pavilion COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0040436

CONTACT PERSON REGARDING THIS REPORT

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
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				1974	6,052,408	155,190	35	172,926	17,736	2,942,065
6										6
7										7
8										8
	Improvement Type**									
9	Various		1993	18,723		20	888	888		18,317
10	Various		1994	6,356		20	318	318		5,916
11	Various		1995	13,538		20	677	677		11,725
12	Various		1996	33,635		20	1,682	1,682		27,384
13	Various		1997	65,081		20	3,254	3,254		50,178
14	Various		1998	86,428		20	4,321	4,321		62,347
15	Various		1999	77,777		20	3,857	3,857		52,860
16	Various		2000	11,922		20	596	596		7,379
17	Various		2001	31,146		20	1,557	1,557		17,897
18	Various		2002	99,866		20	3,697	3,697		99,866
19	Various		2003	39,938		20	3,994	3,994		37,924
20	Various		2004	53,564		20	5,356	5,356		45,894
21	Various		2005	27,344		20	2,188	2,188		21,592
22	Various		2006	19,001		20	2,110	2,110		14,682
23	Various		2007	20,058		20	1,664	1,664		9,578
24	Various		2008	27,237		20	3,800	3,800		17,061
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)		30,837	791		881	90	17,033	68
69	Financial Statement Depreciation			269,531			(269,531)		69
70	TOTAL (lines 4 thru 69)		\$ 6,714,859	\$ 425,512		\$ 213,767	\$ (211,745)	\$ 3,459,697	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:

01/01/12

Ending:

12/31/12

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,714,859	\$ 425,512		\$ 213,767	\$ (211,745)	\$ 3,459,697	1
2	Reinstall Locks	2009	2,568		20	66	66	217	2
3	Plumbing Repairs	2009	3,154		20	81	81	246	3
4	Hot Water Heater	2009	11,488		20	295	295	896	4
5	3 Fire Doors	2009	12,197		20	313	313	951	5
6	Window Replacement	2010	2,985		20	77	77	214	6
7	Frame Install	2010	2,952		20	76	76	192	7
8	Water System	2011	2,657		20	68	68	122	8
9	Heating System	2011	3,979		20	102	102	140	9
10	Electrical Wiring	2011	2,721		20	70	70	84	10
11	Electrical Wiring And Permanent Setup Of Kiosk Walls	2011	10,544		20	270	270	327	11
12	Electrical Wiring And Permanent Setup Of Kiosk Walls	2011	6,717		20	172	172	208	12
13	Hot Water Pump Replacement	2011	4,895		20	126	126	131	13
14	Bathroom- Floor, Wall, Ceiling, Faucet	2011	4,255		20	426	426	461	14
15	Pt Rms - Walls, Flooring, Bathroom Countertops, Lighting, Etc.	2012	103,494		20	5,175	5,175	5,175	15
16	Pt Rms - Walls, Flooring, Window Treatments, Lighting, Etc.	2012	51,246		20	2,562	2,562	2,562	16
17	Pt Rms - Walls, Flooring, Cabinetry, Etc.	2012	133,450		20	6,673	6,673	6,673	17
18	Pt Rms - Walls, Flooring, Cabinetry, Electrical, Etc.	2012	144,445		20	7,222	7,222	7,222	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)		\$ 7,218,605	\$ 425,512		\$ 237,539	\$ (187,973)	\$ 3,485,518	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		\$ 7,218,605	\$ 425,512		\$ 237,539	\$ (187,973)	\$ 3,485,518	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)		\$ 7,218,605	\$ 425,512		\$ 237,539	\$ (187,973)	\$ 3,485,518	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		\$ 7,218,605	\$ 425,512		\$ 237,539	\$ (187,973)	\$ 3,485,518	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)		\$ 7,218,605	\$ 425,512		\$ 237,539	\$ (187,973)	\$ 3,485,518	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		\$ 7,218,605	\$ 425,512		\$ 237,539	\$ (187,973)	\$ 3,485,518	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)		\$ 7,218,605	\$ 425,512		\$ 237,539	\$ (187,973)	\$ 3,485,518	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		\$	\$		\$	\$	\$	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	30,837	791		881	90	17,033	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
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 (12H & 12I lines 1 thru 33)		\$30,837	\$791		\$881	\$90	\$17,033	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	\$238,208	\$	\$17,865	\$17,865	10	\$194,034	71
72	Current Year Purchases	182,455	224	17,142	16,918	10	30,960	72
73	Fully Depreciated Assets	612,850		20	20	10	612,782	73
74								74
75	TOTALS	\$1,033,513	\$224	\$35,027	\$34,803		\$837,776	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		546	546	5	4,508	77
78		Allocated from Dynamic	2010	17,433	1,053	2,591	1,538	5	4,921	78
79										79
80	TOTALS			\$67,859	\$1,053	\$3,137	\$2,084		\$54,870	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$8,468,865	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$426,789	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$275,702	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(151,087)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,378,164	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	\$79,389	86
87	Land 2004 - 2004	4,235			87
88					88
89					89
90					90
91	TOTALS	\$260,543	\$6,572	\$79,389	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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$5,997
- 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		\$	\$6,540	17
18					18
19					19
20					20
21	TOTAL		\$	\$6,540	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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	\$		\$ 222,855	\$		\$ 222,855	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			70,619			70,619	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			364,661			364,661	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				145,470		145,470	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						12,157		12,157	13
14	TOTAL			\$		\$ 658,135	\$ 157,627		\$ 815,762	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	\$ 1,630	\$ 164,935	1
2	Cash-Patient Deposits	94,719	94,719	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	416,731	416,731	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,302	71,302	6
7	Other Prepaid Expenses	5,400	5,400	7
8	Accounts Receivable (owners or related parties)		61,682	8
9	Other(specify): See Attached Schedule	39,937	387,037	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 629,719	\$ 1,201,806	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	1,073,113	1,073,113	15
16	Equipment, at Historical Cost	691,812	975,126	16
17	Accumulated Depreciation (book methods)	(1,011,252)	(4,238,801)	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	254,082	276,395	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,007,755	\$ 4,498,784	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,637,474	\$ 5,700,590	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 494,112	\$ 494,110	26
27	Officer's Accounts Payable	62,500	62,500	27
28	Accounts Payable-Patient Deposits	106,764	106,764	28
29	Short-Term Notes Payable		80,850	29
30	Accrued Salaries Payable	253,088	253,088	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,015	5,015	31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,000	29,000	32
33	Accrued Interest Payable	10,145	10,145	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,702	6,702	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	46,100	46,100	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,013,426	\$ 1,094,274	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,021,688	1,021,688	39
40	Mortgage Payable		5,675,566	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)	\$ 1,021,688	\$ 6,927,154	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,035,114	\$ 8,021,428	46
47	TOTAL EQUITY(page 18, line 24)	\$ (397,640)	\$ (2,320,838)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,637,474	\$ 5,700,590	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (146,706)	1
2	Restatements (describe):		2
3		2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (146,704)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(250,936)	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)	\$ (250,936)	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)	\$ (397,640)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,056,069	1
2	Discounts and Allowances for all Levels	(1,942,898)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,113,171	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,994,640	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,994,640	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	217,392	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,079	19
20	Radiology and X-Ray	8,776	20
21	Other Medical Services	4,177	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 241,424	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,243	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,243	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	99,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 99,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,449,478	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	953,426	31
32	Health Care	1,783,284	32
33	General Administration	1,702,402	33
	B. Capital Expense		
34	Ownership	1,115,986	34
	C. Ancillary Expense		
35	Special Cost Centers	815,762	35
36	Provider Participation Fee	329,554	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,700,414	40
41	Income before Income Taxes (line 30 minus line 40)**	(250,936)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (250,936)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,437,111	44
45	Private Pay - Net Inpatient Revenue	955,490	45
46	Medicare - Net Inpatient Revenue	502,310	46
47	Other-(specify) Hospice	218,260	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,113,171	49

* 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.

****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	1,981	2,063	\$ 79,190	\$ 38.39	1
2	Assistant Director of Nursing	1,464	1,480	43,300	29.26	2
3	Registered Nurses	9,398	9,572	260,535	27.22	3
4	Licensed Practical Nurses	15,453	16,207	369,464	22.80	4
5	CNAs & Orderlies	62,633	68,235	744,907	10.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,953	2,091	26,747	12.79	9
10	Activity Assistants	9,336	10,119	96,837	9.57	10
11	Social Service Workers	3,943	4,179	58,529	14.01	11
12	Dietician					12
13	Food Service Supervisor	1,898	2,091	40,595	19.41	13
14	Head Cook	3,494	3,927	39,812	10.14	14
15	Cook Helpers/Assistants	15,216	16,341	148,916	9.11	15
16	Dishwashers					16
17	Maintenance Workers	3,852	4,102	68,272	16.64	17
18	Housekeepers	11,938	12,738	127,607	10.02	18
19	Laundry	7,654	8,319	78,259	9.41	19
20	Administrator	1,937	2,179	103,155	47.34	20
21	Assistant Administrator					21
22	Other Administrative	868	868	30,000	34.56	22
23	Office Manager					23
24	Clerical	4,763	5,115	85,029	16.62	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)	157,781	169,626	\$ 2,401,154 *	\$ 14.16	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	144	\$ 8,076	01-03	35
36	Medical Director	96	9,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	5,685	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	71	4,371	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	120	6,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	527	\$ 33,732		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:01/01/12

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Ending:12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rhonda Reed	Administrator	0.0%	\$ 103,155
Fred Aaron	Administrative	23.80%	30,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 133,155

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	\$ 16,525
See Attached	Legal	7,490
Adjusted on PG5A	Legal	7,750
Casamba	Data Processing	3,300
Health Data Systems Inc.	Data Processing	16,263
Personnel Planners, Inc.	Unemployment Consulting	1,956
Adjusted on PG5A	Legal	100
Dynamic HC Consultants	Bookkeeping	446,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 499,384

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 222,254	
Unemployment Compensation Insurance	48,072	
FICA Taxes	182,357	
Employee Health Insurance	120,809	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Other Employee Benefits	21,393	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 594,885

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	2,850	
Health Care Worker Background Check (Indicate # of checks performed)	1,840	
Patient Background Checks		
Dues & Subscriptions	5,859	
Licenses and Permits	2,883	
Allocated from Dynamic	510	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 13,941

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	4,424
Allocated from Dynamic	1,893
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 6,317

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

\$

None

Line

N/A
- (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.

\$

209,635

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

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

No

If YES, attach an explanation of the allocation.

- (13)

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

Yes
- (14)

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

No

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

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

\$

N/A

Has any meal income been offset against related costs?

No

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 Ln14

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