

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,165	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	121	TOTALS	121	44,165	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	3,898	5,294	4,968	14,160	8	
9	SNF/PED					9	
10	ICF	12,835	4,475	885	18,195	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	16,733	9,769	5,853	32,355	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.26%

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 4,948

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	223,126	18,679	7,080	248,885		248,885		248,885		1
2	Food Purchase		160,590		160,590		160,590	(480)	160,110		2
3	Housekeeping	130,719	27,181		157,900		157,900		157,900		3
4	Laundry	75,801	16,332		92,133		92,133		92,133		4
5	Heat and Other Utilities			140,289	140,289		140,289	1,107	141,396		5
6	Maintenance	67,056	50,518	55,200	172,774		172,774	21,668	194,442		6
7	Other (specify):*							555	555		7
8	TOTAL General Services	496,702	273,300	202,569	972,571		972,571	22,850	995,421		8
	B. Health Care and Programs										
9	Medical Director			5,800	5,800		5,800		5,800		9
10	Nursing and Medical Records	1,570,526	83,535	5,585	1,659,646		1,659,646	(1,197)	1,658,449		10
10a	Therapy	698	1,680		2,378		2,378		2,378		10a
11	Activities	121,229	1,808		123,037		123,037		123,037		11
12	Social Services	57,192		4,934	62,126		62,126		62,126		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,749,645	87,023	16,319	1,852,987		1,852,987	(1,197)	1,851,790		16
	C. General Administration										
17	Administrative	130,182			130,182		130,182	104,486	234,668		17
18	Directors Fees										18
19	Professional Services			458,911	458,911		458,911	(427,205)	31,706		19
20	Dues, Fees, Subscriptions & Promotions			49,557	49,557		49,557	(27,260)	22,297		20
21	Clerical & General Office Expenses	55,582	1,385	172,569	229,536		229,536	(88,135)	141,401		21
22	Employee Benefits & Payroll Taxes			396,754	396,754		396,754	(379)	396,375		22
23	Inservice Training & Education			298	298		298		298		23
24	Travel and Seminar			1,010	1,010		1,010	289	1,299		24
25	Other Admin. Staff Transportation			4,541	4,541		4,541	427	4,968		25
26	Insurance-Prop.Liab.Malpractice			85,089	85,089		85,089	995	86,084		26
27	Other (specify):*							27,527	27,527		27
28	TOTAL General Administration	185,764	1,385	1,168,729	1,355,878		1,355,878	(409,255)	946,623		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,432,111	361,708	1,387,617	4,181,436		4,181,436	(387,602)	3,793,834		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.

Facility Name & ID Number

Sterling Pavilion

#0040436

Report Period Beginning:

01/01/10

Ending:

12/31/10

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			35,802	35,802		35,802	216,347	252,149			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,210	66,210		66,210	428,632	494,842			32
33	Real Estate Taxes			27,761	27,761		27,761	(3,606)	24,155			33
34	Rent-Facility & Grounds			737,556	737,556		737,556	(737,556)				34
35	Rent-Equipment & Vehicles			3,930	3,930		3,930	5,618	9,548			35
36	Other (specify):*											36
37	TOTAL Ownership			871,259	871,259		871,259	(90,565)	780,694			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		140,192	624,484	764,676		764,676	(1,149)	763,527			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,248	66,248		66,248		66,248			42
43	Other (specify):*	5,600			5,600		5,600	(5,600)				43
44	TOTAL Special Cost Centers	5,600	140,192	690,732	836,524		836,524	(6,749)	829,775			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,437,711	501,900	2,949,608	5,889,219		5,889,219	(484,916)	5,404,303			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	58,833	30		9
10	Interest and Other Investment Income	(6,366)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(480)	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	(446)	21		18
19	Entertainment				19
20	Contributions	(1,600)	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	(108,000)	21		24
25	Fund Raising, Advertising and Promotional	(18,591)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,178)	20		28
29	Other-Attach Schedule	(81,558)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (161,386)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(323,530)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (323,530)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (484,916)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Sterling PavilionID# 0040436Report Period Beginning: 01/01/10Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	COPE Dues	\$ (4,489)	20	1
2	Bank Charges	(5,984)	21	2
3	Account Collection Fees	(5)	21	3
4	PPA - Various Expenses	(4,495)	21	4
5	PPA - Pension	(379)	22	5
6	PPA - Professional Fees	(2,400)	19	6
7	PPA - Lab	(740)	39	7
8	PPA - Medical & Nursing Supplies	(29)	10	8
9	Intercompany Interest	(40,763)	32	9
10	Non-Allowable Travel (Marketing)	(214)	25	10
11	Non-Allowable Legal	(435)	19	11
12	Non-Care Depreciation	(6,572)	30	12
13	Marketing Salary	(5,600)	43	13
14	Building Co. - Amortization	(930)	31	14
15	Building Co. - Bank Fees	(416)	21	15
16	Building Co. - Professional & Legal Fees	(250)	19	16
17	Building Co. - Franchise Tax	(250)	21	17
18	Additional R&M	12,393	06	18
19	PPA - IDPH Penalty	(20,000)	21	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(81,558)		49

Sterling Pavilion

ID# 0040436

Report Period Beginning: 01/01/10

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sterling Pavilion# 0040436

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(480)											(480)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,107									1,107	5
6	Maintenance	12,393		3,616	5,659								21,668	6
7	Other (specify):*					555							555	7
8	TOTAL General Services	11,913		4,723	5,659	555							22,850	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(29)					(1,168)						(1,197)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(29)					(1,168)						(1,197)	16
	C. General Administration													
17	Administrative				104,486								104,486	17
18	Directors Fees													18
19	Professional Services	(3,085)	250	(424,370)									(427,205)	19
20	Fees, Subscriptions & Promotions	(27,858)		598									(27,260)	20
21	Clerical & General Office Expenses	(139,596)	666	43,813	6,982								(88,135)	21
22	Employee Benefits & Payroll Taxes	(379)											(379)	22
23	Inservice Training & Education													23
24	Travel and Seminar			289									289	24
25	Other Admin. Staff Transportation	(214)		641									427	25
26	Insurance-Prop.Liab.Malpractice			995									995	26
27	Other (specify):*			8,501		19,026							27,527	27
28	TOTAL General Administration	(171,132)	916	(369,533)	111,468	19,026							(409,255)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(159,248)	916	(364,810)	117,127	19,581	(1,168)						(387,602)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sterling Pavilion# 0040436

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	52,261	161,674	2,412									216,347	30
31	Amortization of Pre-Op. & Org.	(930)	930											31
32	Interest	(47,129)	472,662	3,099									428,632	32
33	Real Estate Taxes		(5,493)	1,887									(3,606)	33
34	Rent-Facility & Grounds		(737,556)										(737,556)	34
35	Rent-Equipment & Vehicles			5,618									5,618	35
36	Other (specify):*													36
37	TOTAL Ownership	4,202	(107,783)	13,016									(90,565)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(740)					(409)						(1,149)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(5,600)											(5,600)	43
44	TOTAL Special Cost Centers	(6,340)					(409)						(6,749)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(161,386)	(106,867)	(351,794)	117,127	19,581	(1,577)						(484,916)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 737,556	Sterling Building LLC		\$	(737,556)	1
2	V	33 Real Estate Taxes	34,293	Sterling Building LLC		28,800	(5,493)	2
3	V	32 Interest Expense - MB Loan		Sterling Building LLC		6,894	6,894	3
4	V	32 Interest Expense - Cap. Lease		Sterling Building LLC		465,768	465,768	4
5	V	30 Depreciation		Sterling Building LLC		161,674	161,674	5
6	V	31 Amortication		Sterling Building LLC		930	930	6
7	V	21 Bank Fees		Sterling Building LLC		416	416	7
8	V	19 Professional & Legal Fees		Sterling Building LLC		250	250	8
9	V	21 Franchise Tax		Sterling Building LLC		250	250	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 771,849			\$ 664,982	\$ * (106,867)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 1,107	\$ 1,107
16	V	6 REPAIRS & MAINT.				3,616	3,616
17	V	19 PROFESSIONAL FEES				670	670
18	V	20 DUES AND SUBSCRIPTIONS				598	598
19	V	21 CLERICAL & GENERAL				43,813	43,813
20	V	24 SEMINARS AND TRAVEL				289	289
21	V	25 AUTO EXP.				641	641
22	V	26 INSURANCE				995	995
23	V	27 EMP.BEN. - GEN. ADMIN.				8,501	8,501
24	V	30 DEPRECIATION				2,412	2,412
25	V	32 INTEREST				3,099	3,099
26	V	33 REAL ESTATE TAXES				1,887	1,887
27	V	35 EQUIPMENT RENTAL				5,618	5,618
28	V						
29	V	19 BOOKKEEPING	425,040				(425,040)
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 425,040			\$ 73,246	\$ * (351,794)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 5,659	\$	5,659	15
16	V	17 ADMIN. CMP. - M. MAUER				16,334		16,334	16
17	V	17 ADMIN. CMP. - M. AARON				18,521		18,521	17
18	V	17 ADMIN. CMP. - F. AARON				17,200		17,200	18
19	V	17 ADMIN. CMP. - S. GOLDSTEIN							19
20	V	17 ADMIN. CMP. - J. AARON							20
21	V	17 ADMIN. CMP. - S. KOPLIN							21
22	V	17 ADMIN. CMP. - D. MAGAFAS				14,967		14,967	22
23	V	17 ADMIN. CMP. - HOWARD ALTER							23
24	V	17 ADMIN. CMP. - NON-OWNER-V. DAVIS							24
25	V	17 ADMIN. CMP. - NON-OWNER -VAR.				21,128		21,128	25
26	V	17 ADMIN. CMP. - CFO NON OWNER				16,336		16,336	26
27	V	21 CLERICAL CMP. - S. AARON				6,982		6,982	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		\$			\$ 117,127	\$ *	117,127	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 555	\$	555	15
16	V	27 EMP. BEN.- M. MAUER				889		889	16
17	V	27 EMP. BEN.- M. AARON				1,032		1,032	17
18	V	27 EMP. BEN.- F. AARON				7,113		7,113	18
19	V	27 EMP. BEN.- S. GOLDSTEIN							19
20	V	27 EMP. BEN.- J. AARON							20
21	V	27 EMP. BEN.- S. KOPLIN							21
22	V	27 EMP. BEN.- D. MAGAFAS				989		989	22
23	V	27 EMP. BEN.- HOWARD ALTER							23
24	V	27 EMP. BEN.-V. DAVIS							24
25	V	27 EMP. BEN.- NON-OWNER				6,028		6,028	25
26	V	27 EMP. BEN.- CFO NON-OWNER				1,755		1,755	26
27	V	27 EMP. BEN. - S. AARON				1,220		1,220	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		\$			\$ 19,581	\$ *	19,581	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$		15
16	V	10 MEDICAL SUPPLIES	10,090	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	8,922	(1,168)	16
17	V	39 ANCILLARY EXPENSE	3,539	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	3,130	(409)	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		\$ 13,629			\$ 12,052	\$ * (1,577)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending:

12/31/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marshall Mauer	Owner	Administrative	8.26%	See Attached	3.27	6.53%	Alloc. Salary	\$ 16,334	17-7	1
2	Maury Aaron	Owner	Administrative	22.23%	See Attached	3.70	7.41%	Alloc. Salary	18,521	17-7	2
3	Sharon Aaron	Owner	Administrative	0.39%	See Attached	3.27	8.17%	Alloc. Salary	6,982	21-7	3
4	Dennis Nehmer	Owner	Maintenance	0.39%	See Attached	3.70	9.25%	Alloc. Salary	5,659	6-7	4
5	Diania Kufra	Owner	Clerical	0.39%	See Attached	4.63	9.26%	Alloc. Salary	14,967	17-7	5
6	Fred Aaron	Owner	Clerical	23.80%	See Attached	9.00	20.00%	Sal/Alloc Sal	41,200	17-1, 17-7	6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs										9
10	to reflect only amount anticipated to be considered allowable by the IL. Dept of HFS										10
11											11
12											12
13								TOTAL	\$ 103,663		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:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	400,612	11	\$ 13,707	\$ 32,355	\$ 1,107	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	400,612	11	44,776	32,355	3,616	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	400,612	11	8,291	32,355	670	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	400,612	11	7,402	32,355	598	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	400,612	11	542,482	382,381	43,813	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	400,612	11	3,581	32,355	289	6
7	25	AUTO EXP.	PATIENT DAYS	400,612	11	7,935	32,355	641	7
8	26	INSURANCE	PATIENT DAYS	400,612	11	12,320	32,355	995	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	400,612	11	105,262	32,355	8,501	9
10	30	DEPRECIATION	PATIENT DAYS	400,612	11	29,871	32,355	2,412	10
11	32	INTEREST	PATIENT DAYS	400,612	11	38,376	32,355	3,099	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	400,612	11	23,364	32,355	1,887	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	400,612	11	69,556	32,355	5,618	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					\$ 906,923	\$ 382,381	\$ 73,246	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	8	61,112	61,112	4	5,659	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	200,000	200,000	3	16,334	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	200,000	200,000	4	18,521	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	86,000	86,000	9	17,200	4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	89,700	89,700			5
6	17	ADMIN. CMP. - J. AARON	WGHTD. AVG. HOURS	40	1	3,386	3,386			6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	30	3	73,516	73,516			7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	50	8	161,659	161,659	5	14,967	8
9	17	ADMIN. CMP. - HOWARD ALTI	WGHTD. AVG. HOURS	40	1	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER-V	WGHTD. AVG. HOURS	40	1	74,483	74,483			10
11	17	ADMIN. CMP. - NON-OWNER -	WGHTD. AVG. HOURS	45	8	228,000	228,000	4	21,128	11
12	17	ADMIN. CMP. - CFO NON OWN	WGHTD. AVG. HOURS	45	10	200,022	200,022	4	16,336	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	85,429	85,429	3	6,982	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,475,307	\$ 1,475,307		\$ 117,127	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	8	5,988	4	555	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	10,884	3	889	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	11,145	4	1,032	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	35,563	9	7,113	4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	35,796			5
6	27	EMP. BEN.- J. AARON	WGHTD. AVG. HOURS	40	1				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	30	3	25,120			7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	50	8	10,687	5	989	8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,083			9
10	27	EMP. BEN.-V. DAVIS	WGHTD. AVG. HOURS	40	1	16,762			10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	65,051	4	6,028	11
12	27	EMP. BEN.- CFO NON-OWNER	WGHTD. AVG. HOURS	45	10	21,483	4	1,755	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	14,927	3	1,220	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					\$ 254,489	\$	\$ 19,581	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1									1	
2	10	MEDICAL SUPPLIES						8,922	2	
3	39	ANCILLARY EXPENSE						3,130	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					\$	\$	\$	12,052	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending:

12/31/10

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		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			\$	\$ 3,798,282			\$	1							
2	Sterling Building LLC		X	Capitalized Lease				2,142,708				2							
3												3							
4												4							
5	See Supplemental Schedule											5							
	Working Capital																		
6	MB Financial		X	Line of Credit				523,650				24,364	6						
7	MB Financial		X	Insurance Financing								1,083	7						
8	See Supplemental Schedule							173,250				6,894	8						
9	TOTAL Facility Related						\$	\$ 6,637,889			\$	498,109	9						
	B. Non-Facility Related*																		
10	Interest Income		X									(6,366)	10						
11	Allocated From Dynamic											3,099	11						
12													12						
13	See Supplemental Schedule												13						
14	TOTAL Non-Facility Related						\$	\$			\$	(3,267)	14						
15	TOTALS (line 9+line14)						\$	\$ 6,637,889			\$	494,843	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.)

Facility Name & ID Number

Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending:

12/31/10

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																			
	Working Capital																			
8	MB Financial		X	Loan Payable			\$	\$ 173,250			\$ 6,894	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending:

12/31/10

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 Use	2 Square Feet	3 Year Acquired	4 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			\$ 148,888	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	4	
5									5	
6									6	
7									7	
8									8	
Improvement Type**										
9	Various		1993	18,723		20	936	936	16,492	9
10	Various		1994	6,356		20	318	318	5,280	10
11	Various		1995	13,538		20	677	677	10,371	11
12	Various		1996	33,635		20	1,682	1,682	24,021	12
13	Various		1997	65,081		20	3,254	3,254	43,669	13
14	Various		1998	86,428		20	4,321	4,321	53,705	14
15	Various		1999	77,777		20	3,857	3,857	45,147	15
16	Various		2000	11,922		20	596	596	6,187	16
17	Various		2001	31,146		20	1,557	1,557	14,783	17
18	Various		2002	99,866		20	9,987	9,987	86,182	18
19	Various		2003	39,938		20	3,994	3,994	29,936	19
20	Various		2004	53,564		20	5,356	5,356	35,181	20
21	Various		2005	27,344		20	2,945	2,945	16,730	21
22	Various		2006	19,001		20	2,343	2,343	10,346	22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		6,052,408	161,674		172,926	11,252	2,607,377	67
68		35,827	919		1,024	105	17,743	68
69			29,230			(29,230)		69
70		\$ 6,672,554	\$ 191,823		\$ 215,773	\$ 23,950	\$ 3,023,150	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:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,672,554	\$ 191,823		\$ 215,773	\$ 23,950	\$ 3,023,150	1
2	2 Smoke Detectors	2007	1,639		20	234	234	936	2
3	Cubicle Curtains	2007	4,402		20	440	440	1,651	3
4	Cubicle Curtains	2007	4,507		20	451	451	1,728	4
5	Power Supply For Hot Water System	2007	1,276		20	128	128	446	5
6	Thermostats	2007	3,038		20	152	152	582	6
7	Thermostats	2007	2,506		20	125	125	491	7
8	Thermostats	2007	2,691		20	135	135	415	8
9	Remodeled Shower Room	2008	4,389		20	439	439	1,244	9
10	1 Electric Wall Heater	2008	559		20	56	56	159	10
11	Installed New Amplifier	2008	1,341		20	134	134	369	11
12	4 Outdoor Lights	2008	2,179		20	218	218	545	12
13	Heat/Cool Pump	2008	745		20	74	74	186	13
14	Fire/Smoke Dampers	2008	8,900		20	1,780	1,780	4,450	14
15	Fire Alarm System Dampers	2008	1,867		20	373	373	902	15
16	Heat/Cool Heat Pumps	2008	726		20	73	73	175	16
17	Generator Repair	2008	4,199		20	420	420	945	17
18	Plumbing Improvements	2008	736		20	74	74	153	18
19	Plumbing Improvements	2008	1,125		20	113	113	234	19
20	Plumbing Improvements	2008	470		20	47	47	98	20
21	Reinstall Locks	2009	2,568		20	66	66	85	21
22	Plumbing Repairs	2009	3,154		20	81	81	84	22
23	Hot Water Heater	2009	11,488		20	295	295	307	23
24	3 Fire Doors	2009	12,197		20	313	313	326	24
25	Window Replacement	2010	2,985		20	61	61	61	25
26	Frame Install	2010	2,952		20	41	41	41	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,755,192	\$ 191,823		\$ 222,093	\$ 30,270	\$ 3,039,763	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,755,192	\$ 191,823		\$ 222,093	\$ 30,270	\$ 3,039,763	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,755,192	\$ 191,823		\$ 222,093	\$ 30,270	\$ 3,039,763	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,755,192	\$ 191,823		\$ 222,093	\$ 30,270	\$ 3,039,763	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,755,192	\$ 191,823		\$ 222,093	\$ 30,270	\$ 3,039,763	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,755,192	\$ 191,823		\$ 222,093	\$ 30,270	\$ 3,039,763	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,755,192	\$ 191,823		\$ 222,093	\$ 30,270	\$ 3,039,763	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	121 Beds	1974	6,052,408	161,674	35	172,926	11,252	2,607,377	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 Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	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)	\$ 6,052,408	\$ 161,674		\$ 172,926	\$ 11,252	\$ 2,607,377	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Dynamic	1993	35,827	919	35	1,024	105	17,743	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 Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1								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)		\$ 35,827	\$ 919		\$ 1,024	\$ 105	\$ 17,743	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 281,288	\$	\$ 24,489	\$ 24,489	10	\$ 245,928	71
72	Current Year Purchases	4,232		403	403	10	403	72
73	Fully Depreciated Assets	524,641		68	68	10	524,561	73
74								74
75	TOTALS	\$ 810,161	\$	\$ 24,960	\$ 24,960		\$ 770,892	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	2000	\$ 45,441	\$	\$	\$	5	\$ 45,441	76
77		BRUN WHEEL CHAIR LIFT IN	2008	4,985		1,137	1,137	5	3,280	77
78		Allocated from Dynamic	2010	18,590	1,494	3,960	2,466	5	5,704	78
79										79
80	TOTALS			\$ 69,016	\$ 1,494	\$ 5,097	\$ 3,603		\$ 54,425	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,783,257	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 193,317	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 252,150	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 58,833	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,865,080	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	\$ 39,131	86
87	Land 2004 - 2004	4,235			87
88					88
89					89
90					90
91	TOTALS	\$ 260,543	\$ 6,572	\$ 39,131	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	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: \$ 3,930 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	<u>Allocated from Dynamic</u>		\$	\$ <u>5,618</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>5,618</u>	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. _____/2011 \$ _____

13. _____/2012 \$ _____

14. _____/2013 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs				\$ 203,156				\$ 203,156	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				72,343				72,343	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				348,801				348,801	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					125,037			125,037	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): _____											12
13	Other (specify): <u>See Supplemental</u>						184	15,155			15,339	13
14	TOTAL				\$		\$ 624,484	\$ 140,192			\$ 764,676	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion# 0040436Report Period Beginning: 01/01/10Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (19,428)	\$ 185,475	1
2	Cash-Patient Deposits	105,947	105,947	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	92,631	92,631	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,020	43,020	6
7	Other Prepaid Expenses	3,228	3,228	7
8	Accounts Receivable (owners or related parties)		26,182	8
9	Other(specify): <u>See Attached Schedule</u>	55,235	282,335	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 280,633	\$ 738,818	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	585,328	585,328	15
16	Equipment, at Historical Cost	494,857	791,315	16
17	Accumulated Depreciation (book methods)	(671,736)	(3,588,905)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,498	6,498	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,498)	(6,498)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	229,900	254,073	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 638,349	\$ 4,454,762	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 918,982	\$ 5,193,580	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 360,251	\$ 360,250	26
27	Officer's Accounts Payable	62,500	62,500	27
28	Accounts Payable-Patient Deposits	105,947	105,947	28
29	Short-Term Notes Payable		173,250	29
30	Accrued Salaries Payable	226,960	226,960	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,518	2,518	31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,000	28,000	32
33	Accrued Interest Payable	4,650	4,650	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,659	6,659	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	104	104	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 797,589	\$ 970,838	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	523,650	523,650	39
40	Mortgage Payable		5,940,990	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>		229,900	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 523,650	\$ 6,694,540	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,321,239	\$ 7,665,378	46
47	TOTAL EQUITY(page 18, line 24)	\$ (402,257)	\$ (2,471,798)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 918,982	\$ 5,193,580	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (463,629)	1
2	Restatements (describe):		2
3	Rounding Adjustment	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (463,626)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	61,369	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)	\$ 61,369	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)	\$ (402,257)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning: 01/01/10

Ending: 12/31/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,482,665	1
2	Discounts and Allowances for all Levels	(1,773,368)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,709,297	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,923,460	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,923,460	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	186,612	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,653	19
20	Radiology and X-Ray	5,053	20
21	Other Medical Services	10,147	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 213,465	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,366	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,366	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	98,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 98,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,950,588	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	972,571	31
32	Health Care	1,852,987	32
33	General Administration	1,355,878	33
B. Capital Expense			
34	Ownership	871,259	34
C. Ancillary Expense			
35	Special Cost Centers	770,276	35
36	Provider Participation Fee	66,248	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,889,219	40
41	Income before Income Taxes (line 30 minus line 40)**	61,369	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 61,369	43

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

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

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

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

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	1,519	1,589	\$ 52,488	\$ 33.03	1
2	Assistant Director of Nursing	546	713	20,193	28.32	2
3	Registered Nurses	9,550	9,769	249,073	25.50	3
4	Licensed Practical Nurses	21,379	22,562	487,127	21.59	4
5	CNAs & Orderlies	63,484	69,070	761,645	11.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	66	74	698	9.43	8
9	Activity Director	1,973	2,118	26,292	12.41	9
10	Activity Assistants	9,234	10,194	94,937	9.31	10
11	Social Service Workers	3,930	4,122	57,192	13.87	11
12	Dietician					12
13	Food Service Supervisor	1,941	2,126	40,681	19.13	13
14	Head Cook	5,044	5,715	54,554	9.55	14
15	Cook Helpers/Assistants	12,816	14,391	127,891	8.89	15
16	Dishwashers					16
17	Maintenance Workers	3,773	4,630	67,056	14.48	17
18	Housekeepers	11,979	13,501	130,719	9.68	18
19	Laundry	7,771	8,696	75,801	8.72	19
20	Administrator	2,000	2,201	106,182	48.24	20
21	Assistant Administrator					21
22	Other Administrative	712	712	24,000	33.71	22
23	Office Manager					23
24	Clerical	3,697	3,905	55,582	14.23	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	333	333	5,600	16.82	33
34	TOTAL (lines 1 - 33)	161,747	176,421	\$ 2,437,711 *	\$ 13.82	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	144	\$ 7,080	01-03	35
36	Medical Director	116	5,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	140	5,585	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	82	4,934	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	482	\$ 23,399		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Rhonda Reed	Administrator		\$ 106,182	Workers' Compensation Insurance	\$ 75,799	IDPH License Fee	\$	
Fred Aaron	Administrative	23.80	24,000	Unemployment Compensation Insurance	20,125	Advertising: Employee Recruitment	8,375	
				FICA Taxes	178,190	Health Care Worker Background Check	3,700	
				Employee Health Insurance	116,794	(Indicate # of checks performed 370)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising & Promotions	21,769	
				Other Employee Benefits	5,467	Dues & Subscriptions	12,124	
						Licenses & Fees	1,988	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 130,182			Allocated From Dynamic	598	
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 396,375	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
			\$			\$ 22,296		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description		Description		
				Line #		Amount		
C. Professional Services			Amount			Amount		
Vendor/Payee	Type							
Frost, Ruttenberg, & Rothblatt	Accounting		\$ 13,191			Out-of-State Travel		
Personnel Planners, Inc	Unemployment Consulting		1,796			\$		
See Attached	Legal		2,932					
Health Data Systems Inc	Data Processing		15,952			In-State Travel		
Dynamic HC Consultants	Bookkeeping		425,040					
						Seminar Expense		
						1,010		
						Allocated from Dynamic		
						289		
						Entertainment Expense		
						()		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 458,911	\$		TOTAL		
						\$ 1,299		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/10

Ending:

12/31/10

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$10,672 ; IL Assoc. of HC \$1,452
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,762 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 66,248
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? 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% Ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.