

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

<p>I. IDPH License ID Number: <u>0040436</u></p> <p>Facility Name: <u>Sterling Pavilion</u></p> <p>Address: <u>105 East 23rd Street</u> <u>Sterling</u> <u>61081</u> Number City Zip Code</p> <p>County: <u>Whiteside</u></p> <p>Telephone Number: <u>(815) 626-4264</u> Fax # <u>(815) 626-3254</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>4/1/1993</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ * * Subject to the attached Accountants Consulting Report (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ * * Subject to the attached Accountants Consulting Report (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	44,286	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	44,286	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,188	2,063	4,960	8,211	8
9	SNF/PED					9
10	ICF	14,491	5,808	667	20,966	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,679	7,871	5,627	29,177	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.88%

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 4,949

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	234,680	32,877	8,616	276,173		276,173		276,173		1
2	Food Purchase		189,480		189,480		189,480	(507)	188,973		2
3	Housekeeping	138,716	35,849		174,565		174,565		174,565		3
4	Laundry	66,041	12,645		78,686		78,686		78,686		4
5	Heat and Other Utilities			123,683	123,683		123,683	745	124,428		5
6	Maintenance	91,885	33,954	53,332	179,171		179,171	28,314	207,485		6
7	Other (specify):*							662	662		7
8	TOTAL General Services	531,322	304,805	185,631	1,021,758		1,021,758	29,214	1,050,972		8
	B. Health Care and Programs										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	1,539,153	65,157	12,377	1,616,687		1,616,687		1,616,687		10
10a	Therapy		6,210		6,210		6,210		6,210		10a
11	Activities	136,488	6,334		142,822		142,822		142,822		11
12	Social Services	92,703		4,125	96,828		96,828		96,828		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,768,344	77,701	32,102	1,878,147		1,878,147		1,878,147		16
	C. General Administration										
17	Administrative	133,991			133,991		133,991	88,033	222,024		17
18	Directors Fees										18
19	Professional Services			639,005	639,005		639,005	(518,551)	120,454		19
20	Dues, Fees, Subscriptions & Promotions			111,493	111,493		111,493	(68,358)	43,135		20
21	Clerical & General Office Expenses	137,994	1,833	532,557	672,384		672,384	(400,839)	271,545		21
22	Employee Benefits & Payroll Taxes			458,058	458,058		458,058	(8,335)	449,723		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,864	6,864		6,864	1,390	8,254		24
25	Other Admin. Staff Transportation			13,094	13,094		13,094	1,162	14,256		25
26	Insurance-Prop.Liab.Malpractice			149,460	149,460		149,460	2,222	151,682		26
27	Other (specify):*							38,060	38,060		27
28	TOTAL General Administration	271,985	1,833	1,910,531	2,184,349		2,184,349	(865,215)	1,319,134		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,571,651	384,339	2,128,264	5,084,254		5,084,254	(836,001)	4,248,253		29

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

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			174,329	174,329		174,329	128,861	303,190		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			65,080	65,080		65,080	270,405	335,485		32
33	Real Estate Taxes			31,963	31,963		31,963	2,938	34,901		33
34	Rent-Facility & Grounds			451,200	451,200		451,200	(451,200)			34
35	Rent-Equipment & Vehicles			25,491	25,491		25,491	2,095	27,586		35
36	Other (specify):*										36
37	TOTAL Ownership			748,063	748,063		748,063	(46,901)	701,162		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		162,403	656,414	818,817		818,817		818,817		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			213,246	213,246		213,246		213,246		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		162,403	869,660	1,032,063		1,032,063		1,032,063		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,571,651	546,742	3,745,987	6,864,380		6,864,380	(882,902)	5,981,478		45

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

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	(20,218)	30		9
10	Interest and Other Investment Income	(11,976)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(507)	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	(1,696)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(200,151)	21		24
25	Fund Raising, Advertising and Promotional	(64,398)	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	(348,958)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (647,904)		\$	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)	(234,998)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (234,998)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (882,902)		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

Sterling Pavilion

ID# 0040436

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Expense - P.P.	\$ (236,316)	21	1
2	Employee Benefits - P.P.	(8,335)	22	2
3	Data Processing - P.P.	(2,499)	19	3
4	Repairs & Maintenance - P.P.	(865)	06	4
5	Sequestration Expense	(41,774)	21	5
6	Bank Charges	(2,923)	21	6
7	Interest - Intercompany	(42,450)	32	7
8	Additional R&M	19,499	06	8
9	Non-allowable Auto Lease	(6,936)	35	9
10	2017 Annual Report	(196)	20	10
11	PAC Dues	(4,970)	20	11
12	Non-allowable Legal	(7,842)	19	12
13	Building Company - Amortization	(2,542)	36	13
14	Building Company - Bank Fees	(1,033)	21	14
15	Building Company - Licenses	(250)	20	15
16	Building Company - Professional Fees	(2,955)	19	16
17	Non-Care Depreciation	(6,572)	30	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(348,958)		49

Sterling Pavilion

	ID#	<u>0040436</u>
Report Period Beginning:		<u>01/01/16</u>
Ending:		<u>12/31/16</u>

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	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	(507)											(507)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			745									745	5
6	Maintenance	18,634		4,770	4,910								28,314	6
7	Other (specify):*			153		509							662	7
8	TOTAL General Services	18,127		5,668	4,910	509							29,214	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative				88,033								88,033	17
18	Directors Fees													18
19	Professional Services	(13,296)	2,955	(508,210)									(518,551)	19
20	Fees, Subscriptions & Promotions	(69,814)	250	1,206									(68,358)	20
21	Clerical & General Office Expenses	(483,893)	1,033	74,994	7,027								(400,839)	21
22	Employee Benefits & Payroll Taxes	(8,335)											(8,335)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,390									1,390	24
25	Other Admin. Staff Transportation			1,162									1,162	25
26	Insurance-Prop.Liab.Malpractice			2,222									2,222	26
27	Other (specify):*			12,556		25,504							38,060	27
28	TOTAL General Administration	(575,337)	4,238	(414,680)	95,060	25,504							(865,215)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(557,210)	4,238	(409,012)	99,970	26,013							(836,001)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(26,790)	153,639	2,012									128,861	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(54,426)	323,080	1,751									270,405	32
33	Real Estate Taxes			2,938									2,938	33
34	Rent-Facility & Grounds		(451,200)										(451,200)	34
35	Rent-Equipment & Vehicles	(6,936)		9,031									2,095	35
36	Other (specify):*	(2,542)	2,542											36
37	TOTAL Ownership	(90,694)	28,061	15,732									(46,901)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(647,904)	32,299	(393,280)	99,970	26,013							(882,902)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 451,200	Sterling Pavilion Building, LLC	100.00%	\$	\$ (451,200)	1
2	V	32 Interest Expense		Sterling Pavilion Building, LLC	100.00%	323,080	323,080	2
3	V	30 Depreciation		Sterling Pavilion Building, LLC	100.00%	153,639	153,639	3
4	V	36 Amortization		Sterling Pavilion Building, LLC	100.00%	2,542	2,542	4
5	V	21 Bank Fees		Sterling Pavilion Building, LLC	100.00%	1,033	1,033	5
6	V	20 Licenses		Sterling Pavilion Building, LLC	100.00%	250	250	6
7	V	19 Professional Fees		Sterling Pavilion Building, LLC	100.00%	2,955	2,955	7
8	V			Sterling Pavilion Building, LLC				8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 451,200			\$ 483,499	\$ * 32,299	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%	\$ 745	\$	745	15
16	V	6 REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	4,770		4,770	16
17	V	7 EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	153		153	17
18	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	4,190		4,190	18
19	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	1,206		1,206	19
20	V	21 CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	74,994		74,994	20
21	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	1,390		1,390	21
22	V	25 AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	1,162		1,162	22
23	V	26 INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	2,222		2,222	23
24	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	12,556		12,556	24
25	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	2,012		2,012	25
26	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	1,751		1,751	26
27	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	2,938		2,938	27
28	V	19 REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%				28
29	V	35 AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	8,452		8,452	29
30	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	579		579	30
31	V								31
32	V	19 HOME OFFICE	512,400	DYNAMIC HEALTH CARE CONS.	100.00%			(512,400)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 512,400			\$ 119,120	\$ *	(393,280)	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	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 4,910	\$ 4,910
16	V	17 ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	14,760	14,760
17	V	17 ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	16,835	16,835
18	V	17 ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	500	500
19	V	17 ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%		
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%		
21	V	17 ADMIN. CMP. - B. FRIEDMAN		DYNAMIC HEALTH CARE CONS.	100.00%		
22	V	17 ADMIN. CMP. - R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%		
23	V	17 ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%		
24	V	17 ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	12,414	12,414
25	V	17 ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%		
26	V	17 ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	9,817	9,817
27	V	17 ADMIN. CMP. - A. CASSATA (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%		
28	V	17 ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	15,603	15,603
29	V	17 ADMIN. CMP. - CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	18,104	18,104
30	V	21 CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	6,565	6,565
31	V	21 CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	462	462
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 99,970	\$ * 99,970

* 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%	\$ 509	\$	509	15
16	V	27 EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	3,062		3,062	16
17	V	27 EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	3,191		3,191	17
18	V	27 EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	7,947		7,947	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.- B. FRIEDMAN		DYNAMIC HEALTH CARE CONS.	100.00%				21
22	V	27 EMP. BEN.- R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%				22
23	V	27 EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%				23
24	V	27 EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	873		873	24
25	V	27 EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%				25
26	V	27 EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	2,480		2,480	26
27	V	27 EMP. BEN.-A. CASSATA (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%				27
28	V	27 EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	4,414		4,414	28
29	V	27 EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	1,902		1,902	29
30	V	27 EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,351		1,351	30
31	V	27 EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	284		284	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 26,013	\$ *	26,013	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: 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.

Facility Name & ID Number

Sterling Pavilion

0040436

Report Period Beginning:

01/01/16

Ending:

12/31/16

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: 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.

Facility Name & ID Number

Sterling Pavilion

0040436

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	Shareholder	Administrative	8.26%	See Attached	2.95	5.90%	Alloc. Salary	\$ 14,760	17-07	1	
2	Maury Aaron	Shareholder	Administrative	22.23%	See Attached	3.37	6.73%	Alloc. Salary	16,835	17-07	2	
3	Fred Aaron	Shareholder	Administrative	23.80%	See Attached	9	20.00%	Sal/Alloc Sal	38,500	17-01/17-07	3	
4	Esther Maryles	Shareholder	Clerical	4.24%	See Attached	0.21	0.75%	Alloc. Salary	462	21-07	4	
5	Sharon Aaron	Shareholder	Clerical	0.39%	See Attached	2.95	7.38%	Alloc. Salary	6,565	21-07	5	
6	Dennis Nehmer	Shareholder	Maintenance	0.39%	See Attached	3.37	8.43%	Alloc. Salary	4,910	06-07	6	
7	Diania Kufra	Shareholder	Administrative	0.39%	See Attached	4.21	8.42%	Alloc. Salary	12,414	17-07	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	\$ 94,446		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

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/16

Ending: 12/31/16

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

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/16

Ending: 12/31/16

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	415,748	13	\$ 10,619	\$ 29,177	\$ 745	1	
2	6	REPAIRS & MAINT.	PATIENT DAYS	415,748	13	67,972	32,339	29,177	4,770	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	415,748	13	2,182	29,177	153	29,177	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	415,748	13	59,702	29,177	4,190	29,177	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	415,748	13	17,185	29,177	1,206	29,177	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	415,748	13	1,068,604	741,401	29,177	74,994	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	415,748	13	19,810	29,177	1,390	29,177	7
8	25	AUTO EXP.	PATIENT DAYS	415,748	13	16,560	29,177	1,162	29,177	8
9	26	INSURANCE	PATIENT DAYS	415,748	13	31,660	29,177	2,222	29,177	9
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	415,748	13	178,906	29,177	12,556	29,177	10
11	30	DEPRECIATION	PATIENT DAYS	415,748	13	28,663	29,177	2,012	29,177	11
12	32	INTEREST	PATIENT DAYS	415,748	13	24,945	29,177	1,751	29,177	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	415,748	13	41,869	29,177	2,938	29,177	13
14	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	415,748	13		29,177		29,177	14
15	35	AUTO RENTAL	PATIENT DAYS	415,748	13	120,431	29,177	8,452	29,177	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	415,748	13	8,254	29,177	579	29,177	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,697,362	\$ 773,741	\$ 119,120		25

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	58,328	3	4,910	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	3	14,760	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	200,000	3	16,835	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	2,500	9	500	4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	76,541			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	182,833			6
7	17	ADMIN. CMP. - B. FRIEDMAN	WGHTD. AVG. HOURS	40	1	200,000			7
8	17	ADMIN. CMP. - R. AARON	WGHTD. AVG. HOURS	40	1	60,541			8
9	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	3	72,895			9
10	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	8	147,459	4	12,414	10
11	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000			11
12	17	ADMIN. CMP. - V. DAVIS (NON	WGHTD. AVG. HOURS	40	10	133,035	3	9,817	12
13	17	ADMIN. CMP. - A. CASSATA (N	WGHTD. AVG. HOURS	40	1	94,167			13
14	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	8	185,179	4	15,603	14
15	17	ADMIN. CMP. - CFO (NON-OW)	WGHTD. AVG. HOURS	40	10	245,335	3	18,104	15
16	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	89,040	3	6,565	16
17	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	11	62,541	0	462	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,022,394	\$ 2,022,394	\$ 99,970	25

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	6,047	3	509	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	41,488	3	3,062	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	37,909	3	3,191	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	39,733	9	7,947	4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	6,379			5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	36,760			6
7	27	EMP. BEN.- B. FRIEDMAN	WGHTD. AVG. HOURS	40	1	10,395			7
8	27	EMP. BEN.- R. AARON	WGHTD. AVG. HOURS	40	1	4,779			8
9	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	3	27,583			9
10	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	8	10,371	4	873	10
11	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,060			11
12	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	10	33,608	3	2,480	12
13	27	EMP. BEN.-A. CASSATA (NON-OW	WGHTD. AVG. HOURS	40	1	7,352			13
14	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	52,388	4	4,414	14
15	27	EMP. BEN.- CFO (NON-OWNER)	WGHTD. AVG. HOURS	40	10	25,777	3	1,902	15
16	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	18,319	3	1,351	16
17	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	11	38,523	0	284	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 398,471	\$	\$ 26,013	25

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/16

Ending: 12/31/16

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:

01/01/16

Ending: 12/31/16

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:

01/01/16

Ending: 12/31/16

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:

01/01/16

Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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:

01/01/16

Ending: 12/31/16

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

Facility Name & ID Number

Sterling Pavilion

0040436

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	MB Financial		X	Mortgage Payable			\$	\$ 5,760,000			\$	323,080						
2																		
3																		
4																		
5					-													
Working Capital																		
6	MB Financial		X	Line of Credit				905,513				22,630						
7																		
8					-													
9	TOTAL Facility Related						\$	\$ 6,665,513			\$	345,710						
B. Non-Facility Related*																		
10	Interest Income		X									(11,976)						
11	Allocated - Dynamic HC	X										1,751						
12																		
13					-													
14	TOTAL Non-Facility Related						\$	\$			\$	(10,225)						
15	TOTALS (line 9+line14)						\$	\$ 6,665,513			\$	335,484						

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:

01/01/16

Ending:

12/31/16

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										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									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 2015 report.	\$	<u>29,000</u>	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.)	\$	<u>32,901</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>3,901</u>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>31,000</u>	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.	\$	<u>34,901</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<u>27,535</u>	8
	2012	<u>27,281</u>	9
	2013	<u>27,856</u>	10
	2014	<u>28,393</u>	11
	2015	<u>29,963</u>	12

2016 Accrual = \$29,963 x 1.03 = \$31,000 (Rounded)

Allocated - Dynamic HC Consultants - \$2,938

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sterling Pavilion COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0040436

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u> 11-16-402-001 </u>	<u> Long Term Care Property </u>	\$ <u> 28,370.26 </u>	\$ <u> 28,370.26 </u>
2. <u> 11-16-402-013 </u>	<u> Long Term Care Property </u>	\$ <u> 1,592.60 </u>	\$ <u> 1,592.60 </u>
3. <u> 10-23-404-059-0000 </u>	<u> Allocated - Dynamic HC </u>	\$ <u> 40,971.35 </u>	\$ <u> 2,875.35 </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> 70,934.21 </u>	\$ <u> 32,838.21 </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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sterling Pavilion COUNTY Whiteside
 FACILITY IDPH LICENSE NUMBER 0040436
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	\$ _____	\$ _____
2.	_____	\$ _____	\$ _____
3.	_____	\$ _____	\$ _____
4.	_____	\$ _____	\$ _____
5.	_____	\$ _____	\$ _____
6.	_____	\$ _____	\$ _____
7.	_____	\$ _____	\$ _____
8.	_____	\$ _____	\$ _____
9.	_____	\$ _____	\$ _____
10.	_____	\$ _____	\$ _____
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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning:

01/01/16 Ending:

12/31/16

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

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, 5. Rows include Facility, Sterling Building LLC, and TOTALS.

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	121		1974	\$ 6,052,408	\$ 147,067	35	\$ 172,926	\$ 25,859	\$ 3,633,769	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1993	18,723		20			18,721	9
10	Various		1994	6,356		20			6,356	10
11	Various		1995	13,538		20			13,536	11
12	Various		1996	33,635		20	1,198	1,198	33,627	12
13	Various		1997	33,822		20	1,689	1,689	33,365	13
14	Various		1998	35,361		20	1,768	1,768	33,460	14
15	Various		1999	47,068		20	2,321	2,321	42,055	15
16	Various		2000	11,922		20	596	596	9,764	16
17	Various		2001	21,256		20	1,063	1,063	16,544	17
18	Various		2002	95,605		20			95,605	18
19	Various		2003	29,333		20			29,333	19
20	Various		2004	53,564		20			53,564	20
21	Various		2005	27,344		20	241	241	25,449	21
22	Various		2006	19,001		20	304	304	19,001	22
23	Various		2007	20,058		20	1,430	1,430	15,532	23
24	Various		2008	27,237		20	1,647	1,647	24,757	24
25	Various		2009	29,407		20	754	754	5,326	25
26	Various		2010	5,936		20	152	152	1,015	26
27	Various		2011	18,507		20	791	791	4,102	27
28	Various		2012	339,689		20	16,984	16,984	69,353	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

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								67
68			31,132	798	889	91	20,754	68
69				174,329		(174,329)		69
70			\$ 6,970,902	\$ 322,194		\$ 204,753	\$ (117,441)	\$ 4,204,989 70

**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:

01/01/16

Ending:

12/31/16

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		\$ 6,970,902	\$ 322,194		\$ 204,753	\$ (117,441)	\$ 4,204,989	1
2	Heating Pump In And Furnace	2013	7,720		20	198	198	701	2
3	Flooring Materials	2013	18,272		20	3,654	3,654	13,095	3
4	Construction Work On Handrails	2013	7,228		20	185	185	672	4
5	Corner Guards For Wall & Door Protection	2013	3,785		20	757	757	2,713	5
6	Heat Pumps	2013	7,452		20	191	191	677	6
7	Install Doors In Dining Room Storage, Office South Wall	2013	5,302		20	136	136	481	7
8	Remove And Install Front & Rear Doors	2013	5,990		20	154	154	544	8
9	Sign	2013	6,565		20	438	438	1,568	9
10	Drywall	2013	6,000		20	154	154	545	10
11	Replaced Door & Frames In Boiler And Laundry Room	2013	7,265		20	186	186	660	11
12	Hard Wire Existing Em Lights, Change Hallway Light Over Gen	2013	3,285		20	84	84	291	12
13	Office Wallcoverings	2013	2,724		20	70	70	242	13
14	Replaced Door & Frames Of Courtyard Entrances, Install Front V	2013	5,824		20	149	149	516	14
15	Wallpaper Main Office	2013	2,601		20	67	67	225	15
16	Remove And Replace Front Reception Windows, East Wall	2013	3,206		20	82	82	277	16
17	Window Treatments	2013	9,926		20	1,985	1,985	6,617	17
18	Plumbing & Pipe Work For B Wing Water Heater	2013	7,928		20	203	203	669	18
19	Drywall And Prime Front Office, Entryway, Front Lobby, Cafeter	2013	4,300		20	110	110	363	19
20	Fixtures, Lighting Accessories In Private Dining, Lighting Sconces	2013	6,359		20	1,272	1,272	4,239	20
21	Electric Stand	2013	2,757		20	551	551	1,884	21
22	Electrical And Wall Work	2013	4,451		20	114	114	376	22
23	Floor Primer, Glue Down Carpet	2013	3,870		20	774	774	2,515	23
24	Drywall & Paint 4 Rooms	2013	6,400		20	164	164	526	24
25	Wall Protection	2013	4,551		20	117	117	374	25
26	Remove And Replace Parking Lot Pavement	2013	3,000		20	77	77	247	26
27	200 Wing - Ceiling Lights & Tile, Wallpaper Install	2013	21,943		20	1,097	1,097	4,114	27
28	300 Wing - Dementia Area Cabinets, Corridor Handrails	2013	12,185		20	609	609	2,285	28
29	Therapy Remodel - Cabinets, Tile & Wallpaper Install	2013	3,673		20	184	184	689	29
30	200 Corridor Window Treatments & Wallcovering	2013	38,639		20	1,932	1,932	6,601	30
31	Fire Systems	2014	2,820		20	403	403	1,209	31
32	Flooring Work	2014	3,504		20	90	90	266	32
33	Security System	2014	2,550		20	364	364	1,063	33
34	TOTAL (lines 1 thru 33)		\$ 7,202,977	\$ 322,194		\$ 221,306	\$ (100,888)	\$ 4,262,233	34

**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:

01/01/16

Ending:

12/31/16

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 12B, Carried Forward		\$ 7,202,977	\$ 322,194		\$ 221,306	\$ (100,888)	\$ 4,262,233	1
2	Electrical Work	2014	2,500		20	64	64	179	2
3	30 Cameras	2014	6,750		20	964	964	2,652	3
4	Boiler Room Work	2014	26,160		20	671	671	1,761	4
5	Windows	2014	2,527		20	65	65	170	5
6	Rtu Equipment	2014	15,911		20	1,591	1,591	3,712	6
7	Plumbing And Piping	2014	11,105		20	285	285	653	7
8	Plumbing Work / Remodeling	2015	5,222		20	261	261	500	8
9	Remodeling - Tile & Brickwork In Kitchen	2015	5,987		20	299	299	549	9
10	Cameras	2015	4,255		20	213	213	390	10
11	Bathroom Remodel-Pipe Cover, Shower Rom Toilet Flange	2015	3,721		20	186	186	341	11
12	Bathroom - Install Sink/Faucet, Floor, Lighting Work	2015	7,253		20	363	363	574	12
13	Installed Pump 115V Inline Br 2-1/2" Kit	2016	2,878		20	48	48	48	13
14	Video Monitoring System	2016	3,227		20	484	484	484	14
15	Install New Wall Flashing	2016	3,002		20	150	150	150	15
16	Installed New Door Holders For Security System	2016	2,990		20	149	149	149	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)		\$ 7,306,464	\$ 322,194		\$ 227,099	\$ (95,095)	\$ 4,274,546	34

**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:

01/01/16

Ending:

12/31/16

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		\$ 7,306,464	\$ 322,194		\$ 227,099	\$ (95,095)	\$ 4,274,546	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)	\$ 7,306,464	\$ 322,194		\$ 227,099	\$ (95,095)	\$ 4,274,546	34

**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		\$ 7,306,464	\$ 322,194		\$ 227,099	\$ (95,095)	\$ 4,274,546	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)	\$ 7,306,464	\$ 322,194		\$ 227,099	\$ (95,095)	\$ 4,274,546	34

**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:

01/01/16

Ending:

12/31/16

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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$

**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 (lines 1 thru 33)	\$	\$		\$	\$	\$	34

**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	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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated - Dynamic HC Consultants	1993	31,132	798	20	889	91	20,754	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	TOTAL (lines 1 thru 33)		\$ 31,132	\$ 798		\$ 889	\$ 91	\$ 20,754	34

**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		\$ 31,132	\$ 798		\$ 889	\$ 91	\$ 20,754	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)	\$ 31,132	\$ 798		\$ 889	\$ 91	\$ 20,754	34

**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	\$ 512,401	\$ 450	\$ 73,486	\$ 73,036	10	\$ 397,412	71
72	Current Year Purchases	8,372		520	520	10	520	72
73	Fully Depreciated Assets	697,646		201	201	10	697,577	73
74								74
75	TOTALS	\$ 1,218,419	\$ 450	\$ 74,206	\$ 73,756		\$ 1,095,508	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				5	4,985	77
78		Allocated - Dynamic HC Consult	2016	20,776	763	1,884	1,121	5	1,884	78
79										79
80	TOTALS			\$ 71,202	\$ 763	\$ 1,884	\$ 1,121		\$ 52,310	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)	\$ 8,744,973	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 323,407	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 303,189	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (20,218)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,422,364	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 - 1900	\$ 256,308	\$ 6,572	\$ 105,974	86
87	Land - 2004 - 1900	4,235			87
88					88
89					89
90					90
91	TOTALS	\$ 260,543	\$ 6,572	\$ 105,974	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. 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

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. _____ /2017 \$ _____

13. _____ /2018 \$ _____

14. _____ /2019 \$ _____

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: \$ 10,242 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	Facility	2015 Ford Starcraft	\$ 741	\$ 8,892	17
18	Allocated - Dynamic HC Consultants			8,452	18
19					19
20					20
21	TOTAL		\$ 741	\$ 17,344	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.

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				\$ 215,024				\$ 215,024	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				91,591				91,591	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				349,153				349,153	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					148,882			148,882	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>						646	13,521			14,167	13
14	TOTAL				\$		\$ 656,414	\$ 162,403			\$ 818,817	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16

(last day of reporting year)

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	\$ 123,820	\$ 311,164	1
2	Cash-Patient Deposits	66,225	66,225	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,535,934	1,535,934	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	82,677	82,677	6
7	Other Prepaid Expenses	89,517	89,517	7
8	Accounts Receivable (owners or related parties)		1,320,051	8
9	Other(specify): <u>See Attached Schedule</u>	75,337	100,220	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,973,510	\$ 3,505,788	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		5,991,902	14
15	Leasehold Improvements, at Historical Cost	1,477,681	1,477,681	15
16	Equipment, at Historical Cost	933,814	1,190,840	16
17	Accumulated Depreciation (book methods)	(1,514,201)	(5,333,402)	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>	254,682	53,603	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,151,976	\$ 3,484,859	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,125,486	\$ 6,990,647	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 470,891	\$ 470,890	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,225	66,225	28
29	Short-Term Notes Payable	905,513	905,513	29
30	Accrued Salaries Payable	276,279	276,279	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,955	15,955	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,000	31,000	32
33	Accrued Interest Payable	8,298	8,298	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	201,154	205,354	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,975,315	\$ 1,979,514	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,760,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	1,539,051	1,539,051	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,539,051	\$ 7,299,051	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,514,366	\$ 9,278,565	46
47	TOTAL EQUITY(page 18, line 24)	\$ (388,880)	\$ (2,287,918)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,125,486	\$ 6,990,647	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 103,554	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 103,553	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(492,433)	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)	\$ (492,433)	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)	\$ (388,880)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning: 01/01/16

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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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,915,684	1
2	Discounts and Allowances for all Levels	(2,047,472)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,868,212	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,158,800	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,158,800	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	224,132	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,720	19
20	Radiology and X-Ray	5,256	20
21	Other Medical Services	8,851	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 245,959	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,976	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,976	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	87,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 87,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,371,947	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,021,758	31
32	Health Care	1,878,147	32
33	General Administration	2,184,349	33
B. Capital Expense			
34	Ownership	748,063	34
C. Ancillary Expense			
35	Special Cost Centers	818,817	35
36	Provider Participation Fee	213,246	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,864,380	40
41	Income before Income Taxes (line 30 minus line 40)**	(492,433)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (492,433)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,073,933	44
45	Private Pay - Net Inpatient Revenue	1,264,174	45
46	Medicare - Net Inpatient Revenue	430,489	46
47	Other-(specify) <u>Hospice</u>	99,616	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,868,212	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.

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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	1,392	1,607	\$ 50,464	\$ 31.40	1
2	Assistant Director of Nursing	1,083	1,177	32,152	27.32	2
3	Registered Nurses	4,992	5,139	159,429	31.02	3
4	Licensed Practical Nurses	20,485	21,813	545,143	24.99	4
5	CNAs & Orderlies	49,718	52,510	725,452	13.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,899	2,017	27,748	13.76	9
10	Activity Assistants	10,518	11,251	108,740	9.66	10
11	Social Service Workers	5,233	5,729	92,703	16.18	11
12	Dietician					12
13	Food Service Supervisor	1,939	2,097	34,692	16.54	13
14	Head Cook	4,795	5,191	52,691	10.15	14
15	Cook Helpers/Assistants	14,409	15,237	147,297	9.67	15
16	Dishwashers					16
17	Maintenance Workers	5,674	6,024	91,885	15.25	17
18	Housekeepers	11,702	12,557	138,716	11.05	18
19	Laundry	6,161	6,584	66,041	10.03	19
20	Administrator	1,954	2,134	95,491	44.75	20
21	Assistant Administrator					21
22	Other Administrative	468	468	38,500	82.26	22
23	Office Manager	1,680	1,688	43,012	25.48	23
24	Clerical	5,325	5,805	94,982	16.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,993	2,185	26,513	12.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	151,420	161,213	\$ 2,571,651 *	\$ 15.95	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	151	\$ 8,616	01-03	35
36	Medical Director	96	15,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Per Bed	6,377	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	63	4,125	12-03	45
46	Other(specify)				46
47	Psychiatric	12	6,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	321	\$ 40,718		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

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	0	\$ 95,491	Workers' Compensation Insurance	\$ 48,358	IDPH License Fee	\$ 1,990	
Fred Aaron	Administrative	23.802%	38,500	Unemployment Compensation Insurance	37,017	Advertising: Employee Recruitment	19,727	
				FICA Taxes	194,594	Health Care Worker Background Check	2,436	
				Employee Health Insurance	148,806	(Indicate # of checks performed 244)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	13,175	
				Employee Benefits - Other	20,948	Licenses & Permits	4,601	
TOTAL (agree to Schedule V, line 17, col. 1)						Allocated - Dynamic HC Consultants	1,206	
(List each licensed administrator separately.)			\$ 133,991			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 43,135	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Wescom Solutions	E.H.R.		\$ 39,354			\$	Out-of-State Travel	\$
Personnel Planners	Unemployment Consulting		1,302					
Marcum	Accounting		22,564					
Dynamic HC Consultants	Bookkeeping/Home Office		512,400				In-State Travel	
Dynamic HC Consultants	Data Processing		8,407					
Casamba	EMR for Therapy		4,225					
eHealth Data Solutions	Risk Management Software		4,204				Seminar Expense	6,864
Health Data Systems	Clinical / E.H.R.		10,548				Allocated - Dynamic HC Consultants	1,390
National Datacare Corporation	Data Processing		2,738					
IIT/Source Tech	Data Processing		2,050				Entertainment Expense	()
NTT Data LTC Solutions	Data Processing		12,137				(agree to Sch. V, line 24, col. 8)	
See Supplemental Schedule			19,077				TOTAL	\$ 8,254
TOTAL (agree to Schedule V, line 19, column 3)			\$ 639,006	TOTAL		\$		
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sterling Pavilion

0040436

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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. ICLTC \$15,060
- (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. \$ 130 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. 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. \$ 213,246
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees