FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0040436

Facility Name: Sterling Pavilion

Address: 105 E. 23Rd Street (Number) Sterling (City) 61081 (Zip Code)

County: Whiteside

Telephone Number: (815) 626-4264 **Fax #** (815) 626-3254

HFS ID Number:

Date of Initial License for Current Owners: 4/1/1993

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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**

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,142	1,255	4,353	6,750	8
9	SNF/PED					9
10	ICF	13,927	3,533	3,455	20,915	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,069	4,788	7,808	27,665	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.64%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 [X]

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

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 [X] Date 04/01/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 121 and days of care provided 4,296

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	235,891	39,046	8,340	283,277		283,277		283,277			1
2	Food Purchase		176,732		176,732		176,732	(303)	176,429			2
3	Housekeeping	160,436	35,864		196,300		196,300		196,300			3
4	Laundry	81,314	21,920		103,234		103,234		103,234			4
5	Heat and Other Utilities			132,398	132,398		132,398	(7,625)	124,773			5
6	Maintenance	80,772	30,742	50,358	161,872		161,872	23,013	184,885			6
7	Other (specify):*							734	734			7
8	TOTAL General Services	558,413	304,304	191,096	1,053,813		1,053,813	15,819	1,069,632			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	1,510,675	88,432	45,641	1,644,748		1,644,748	(2,784)	1,641,964			10
10a	Therapy	129,702	4,378		134,080		134,080		134,080			10a
11	Activities	143,186	7,886		151,072		151,072		151,072			11
12	Social Services	114,036		10,489	124,525		124,525		124,525			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,897,599	100,696	71,730	2,070,025		2,070,025	(2,784)	2,067,241			16
	C. General Administration											
17	Administrative	137,224			137,224		137,224	105,879	243,103			17
18	Directors Fees											18
19	Professional Services			606,596	606,596	(203)	606,393	(456,368)	150,025			19
20	Dues, Fees, Subscriptions & Promotions			97,843	97,843		97,843	(66,030)	31,813			20
21	Clerical & General Office Expenses	134,722	1,648	509,606	645,976		645,976	(375,339)	270,637			21
22	Employee Benefits & Payroll Taxes			448,997	448,997		448,997	(72)	448,925			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,308	4,308		4,308	270	4,578			24
25	Other Admin. Staff Transportation			7,560	7,560		7,560	2,767	10,327			25
26	Insurance-Prop.Liab.Malpractice			152,218	152,218		152,218	3,247	155,465			26
27	Other (specify):*							41,754	41,754			27
28	TOTAL General Administration	271,946	1,648	1,827,128	2,100,722	(203)	2,100,519	(743,891)	1,356,628			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,727,958	406,648	2,089,954	5,224,560	(203)	5,224,357	(730,855)	4,493,502			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.

Facility Name & ID Number Sterling Pavilion #0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			146,767	146,767		146,767	146,301	293,068			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			86,428	86,428		86,428	243,567	329,995			32
33	Real Estate Taxes			29,385	29,385	203	29,588	2,521	32,109			33
34	Rent-Facility & Grounds			451,200	451,200		451,200	(451,200)				34
35	Rent-Equipment & Vehicles			34,591	34,591		34,591	3,226	37,817			35
36	Other (specify):*											36
37	TOTAL Ownership			748,371	748,371	203	748,574	(55,585)	692,989			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		179,015	645,784	824,799		824,799		824,799			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			183,071	183,071		183,071		183,071			42
43	Other (specify):*	20,209		4,200	24,409		24,409	(24,409)	0			43
44	TOTAL Special Cost Centers	20,209	179,015	833,055	1,032,279		1,032,279	(24,409)	1,007,870			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,748,167	585,663	3,671,380	7,005,210		7,005,210	(810,848)	6,194,362			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: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,432)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,032)	30		9
10	Interest and Other Investment Income	(14,083)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(303)	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	(5,591)	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	(226,612)	21		24
25	Fund Raising, Advertising and Promotional	(60,236)	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	(338,678)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (656,967)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(153,881)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (153,881)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (810,848)		37

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

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

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

Sterling Pavilion

ID# 0040436

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration Expense	$ (50,584)	21	1
2	Marketing Coordinator Salary	(20,209)	43	2
3	Marketing Consultant	(4,200)	43	3
4	Bank Charges	(5,204)	21	4
5	Miscellaneous Income	(20)	21	5
6	Nursing and Medical Records - Prior Period	(2,784)	10	6
7	Repairs & Maintenance - Prior Period	(351)	06	7
8	Professional Fees - Prior Period	(7,754)	19	8
9	Miscellaneous Expenses - Prior Period	(168,606)	21	9
10	Non Allowable Legal Fees	(21,027)	19	10
11	Employee Benefits - Prior Period	(72)	22	11
12	Building Company - Amortization	(2,542)	36	12
13	Building Company - Bank Fees	(3,596)	21	13
14	Building Company - Licenses	(250)	20	14
15	Building Company - Professional Fees	(2,758)	19	15
16	Interest - Intercompany	(38,338)	32	16
17	Additional R&M	11,824	06	17
18	Non-Care Depreciation	(6,572)	30	18
19	Non-Allowable Auto Lease	(6,936)	35	19
20	PAC Dues	(8,700)	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**	(338,678)		49

Sterling Pavilion

ID# 0040436

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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:** 01/01/17 **Ending:** 12/31/17

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(303)											(303)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,432)		807									(7,625)	5
6	Maintenance	11,473		6,266	5,275								23,013	6
7	Other (specify):*			164		570							734	7
8	**TOTAL General Services**	2,738		7,237	5,275	570							15,819	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,784)											(2,784)	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**	(2,784)											(2,784)	16
	C. General Administration													
17	Administrative				105,879								105,879	17
18	Directors Fees													18
19	Professional Services	(31,540)	2,758	(427,586)									(456,368)	19
20	Fees, Subscriptions & Promotions	(69,186)	250	2,906									(66,030)	20
21	Clerical & General Office Expenses	(460,212)	3,596	75,169	6,109								(375,339)	21
22	Employee Benefits & Payroll Taxes	(72)											(72)	22
23	Inservice Training & Education													23
24	Travel and Seminar			270									270	24
25	Other Admin. Staff Transportation			2,767									2,767	25
26	Insurance-Prop.Liab.Malpractice			3,247									3,247	26
27	Other (specify):*			11,964		29,790							41,754	27
28	**TOTAL General Administration**	(561,010)	6,604	(331,263)	111,988	29,790							(743,891)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(561,056)	6,604	(324,026)	117,263	30,360							(730,855)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sterling Pavilion # 0040436 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(9,604)	153,639	2,266									146,301	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(52,421)	294,600	1,388									243,567	32
33	Real Estate Taxes			2,521									2,521	33
34	Rent-Facility & Grounds		(451,200)										(451,200)	34
35	Rent-Equipment & Vehicles	(6,936)		10,162									3,226	35
36	Other (specify):*	(2,542)	2,542											36
37	**TOTAL Ownership**	(71,503)	(419)	16,337									(55,585)	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):*	(24,409)											(24,409)	43
44	**TOTAL Special Cost Centers**	(24,409)											(24,409)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(656,967)	6,185	(307,689)	117,263	30,360							(810,848)	45

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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%	294,600	294,600	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%	3,596	3,596	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%	2,758	2,758	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 451,200			$ 457,385	$ * 6,185	14

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 807	$ 807	15
16	V	6	REPAIRS & MAINT. - SALARIES		DYNAMIC HEALTH CARE CONS.	100.00%	2,447	2,447	16
17	V	6	REPAIRS & MAINT. - OTHER EXPENSE		DYNAMIC HEALTH CARE CONS.	100.00%	3,819	3,819	17
18	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	164	164	18
19	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	470	470	19
20	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	2,906	2,906	20
21	V	21	CLERICAL & GENERAL - SALARIES		DYNAMIC HEALTH CARE CONS.	100.00%	53,620	53,620	21
22	V	21	CLERICAL & GENERAL - OTHER EXPENSE		DYNAMIC HEALTH CARE CONS.	100.00%	21,549	21,549	22
23	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	270	270	23
24	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	2,767	2,767	24
25	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	3,247	3,247	25
26	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	11,964	11,964	26
27	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	2,266	2,266	27
28	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	1,388	1,388	28
29	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	2,521	2,521	29
30	V	19	REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%	203	203	30
31	V	35	AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	9,745	9,745	31
32	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	417	417	32
33	V								33
34	V	19	HOME OFFICE	428,259	DYNAMIC HEALTH CARE CONS.	100.00%		(428,259)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 428,259			$ 120,570	$ * (307,689)	39

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 5,275	$ 5,275	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	15,661	15,661	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	18,086	18,086	17
18	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	500	500	18
19	V	17	ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	6,162	6,162	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	17	ADMIN. CMP. - R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	17	ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	13,372	13,372	23
24	V	17	ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			24
25	V	17	ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	10,479	10,479	25
26	V	17	ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	22,822	22,822	26
27	V	17	ADMIN. CMP. - CFO (NON-OWNER) .		DYNAMIC HEALTH CARE CONS.	100.00%	18,797	18,797	27
28	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	6,070	6,070	28
29	V	21	CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	39	39	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 117,263	$ * 117,263	39

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 570	$ 570	15
16	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	2,949	2,949	16
17	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	3,760	3,760	17
18	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	8,509	8,509	18
19	V	27	EMP. BEN.- D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	623	623	19
20	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	27	EMP. BEN.- R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	27	EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	1,040	1,040	23
24	V	27	EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			24
25	V	27	EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	2,810	2,810	25
26	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	6,198	6,198	26
27	V	27	EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	2,172	2,172	27
28	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,451	1,451	28
29	V	27	EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	278	278	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			$			$ 30,360	$ * 30,360	39

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	MAURICE I. AARON	22.23%	BRIDGEVIEW HEALTH CARE CENTER, LTD.	BRIDGEVIEW	STERLING BUILDING LLC		BUILDING CO.	1
2	FRED L. AARON	23.80%	GROSSE POINTE MANOR, L.L.C.	NILES	DYNAMIC HEALTH CARE	SKOKIE	BOOKEEPING/CONSULTING	2
3	MARSHALL A. MAUER	8.26%	OTTAWA PAVILION, LTD.	OTTAWA				3
4	ABRAHAM J. STERN	4.96%	PARK RIDGE CARE CENTER, LTD.	PARK RIDGE				4
5	MIRIAM LATINIK	4.13%	WATERFRONT TERRACE, INC.	CHICAGO				5
6	SHIMON GOLDSTEIN	4.13%	WILLOW CREST NURSING PAVILION, LTD.	SANDWICH				6
7	SUSAN ALTER	4.92%	WINDMILL NURSING PAVILION, LTD.	SOUTH HOLLAND				7
8	SYLVIA AARON	1.81%	WOODBRIDGE NURSING PAVILION, LTD.	CHICAGO				8
9	CHANI MAUER	4.24%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG (S	GALESBURG				9
10	DENNIS NEHMER	0.39%	WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO (SLI	GENESEO				10
11	DIANIA KUFTA	0.39%						11
12	ESTHER MARYLES	4.24%						12
13	SUE KOPLIN HARAMARAS	0.39%						13
14	SUSAN L. STERN	4.96%						14
15	FRANCES MAUER	8.26%						15
16	TODD ANDREW STERN TRUST DTD 10/31/01	0.83%						16
17	MICHAEL LOVALLO, TRUSTEE FOR EVAN	0.83%						17
18	SHARON AARON	0.39%						18
19	JONATHAN BRYAN STERN TRUST DTD	0.83%						19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marshall Mauer	Shareholder	Administrative	8.26%	See Attached	3.13	6.26%	Alloc Salary	$ 15,661	17-07	1
2	Maury Aaron	Shareholder	Administrative	22.23%	See Attached	3.62	7.23%	Alloc Salary	18,086	17-07	2
3	Fred Aaron	Shareholder	Administrative	23.80%	See Attached	9	20.00%	Sal/Alloc Sal	42,500	17-01/17-07	3
4	Esther Maryles	Shareholder	Clerical	4.24%	See Attached	0.22	0.78%	Alloc Salary	39	21-07	4
5	Sharon Aaron	Shareholder	Clerical	0.39%	See Attached	3.13	7.82%	Alloc Salary	6,070	21-07	5
6	Dennis Nehmer	Shareholder	Maintenance	0.39%	See Attached	3.62	9.04%	Alloc Salary	5,275	06-07	6
7	Diania Kufta	Shareholder	Administrative	0.39%	See Attached	3.62	9.04%	Alloc Salary	13,372	17-07	7
8	Daniel Aaron	Relative	Administrative	0	See Attached	3.22	8.04%	Alloc Salary	6,162	17-07	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	$ 107,165		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: 01/01/17 Ending: 12/31/17

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 01/01/17 Ending: 12/31/17

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	371,884	11	$ 10,844	$	27,665	$ 807	1
2	6	REPAIRS & MAINT. - SALARIE	PATIENT DAYS	371,884	11	32,891	32,891	27,665	2,447	2
3	6	REPAIRS & MAINT. - OTHER E	PATIENT DAYS	371,884	11	51,340		27,665	3,819	3
4	7	EMP. BEN-GEN SERV.	PATIENT DAYS	371,884	11	2,209		27,665	164	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	371,884	11	6,316		27,665	470	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	371,884	11	39,064		27,665	2,906	6
7	21	CLERICAL & GENERAL - SALA	PATIENT DAYS	371,884	11	720,780	720,780	27,665	53,620	7
8	21	CLERICAL & GENERAL - OTH	PATIENT DAYS	371,884	11	289,675		27,665	21,549	8
9	24	SEMINARS AND TRAVEL	PATIENT DAYS	371,884	11	3,633		27,665	270	9
10	25	AUTO EXP.	PATIENT DAYS	371,884	11	37,201		27,665	2,767	10
11	26	INSURANCE	PATIENT DAYS	371,884	11	43,644		27,665	3,247	11
12	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	371,884	11	160,819		27,665	11,964	12
13	30	DEPRECIATION	PATIENT DAYS	371,884	11	30,466		27,665	2,266	13
14	32	INTEREST	PATIENT DAYS	371,884	11	18,656		27,665	1,388	14
15	33	REAL ESTATE TAXES	PATIENT DAYS	371,884	11	33,889		27,665	2,521	15
16	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	371,884	11	2,725		27,665	203	16
17	35	AUTO RENTAL	PATIENT DAYS	371,884	11	130,997		27,665	9,745	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	371,884	11	5,607		27,665	417	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,620,756	$ 753,671		$ 120,570	25

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	7	58,337	58,337	3.62	5,275	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	3.13	15,661	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	7	200,000	200,000	3.62	18,086	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	2,500	2,500	9.00	500	4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	11	76,541	76,541	3.22	6,162	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	101,000	101,000	-		6
7	17	ADMIN. CMP. - R. AARON	WGHTD. AVG. HOURS	40	1	61,541	61,541	-		7
8	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	3	71,909	71,909	-		8
9	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	40	7	147,753	147,753	3.62	13,372	9
10	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		10
11	17	ADMIN. CMP. - V. DAVIS (NON	WGHTD. AVG. HOURS	40	9	133,816	133,816	3.13	10,479	11
12	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	7	252,333	252,333	4.07	22,822	12
13	17	ADMIN. CMP. - CFO (NON-OWI	WGHTD. AVG. HOURS	40	9	240,048	240,048	3.13	18,797	13
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	9	77,614	77,614	3.13	6,070	14
15	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	11	5,000	5,000	0.22	39	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,640,392	$ 1,640,392		$ 117,263	25

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	7	6,305		3.62	570	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	37,655		3.13	2,949	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	7	41,575		3.62	3,760	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	42,544		9.00	8,509	4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	11	7,737		3.22	623	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,621		-		6
7	27	EMP. BEN.- R. AARON	WGHTD. AVG. HOURS	40	1	27,046		-		7
8	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	3	28,711		-		8
9	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	40	7	11,492		3.62	1,040	9
10	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,095		-		10
11	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	9	35,890		3.13	2,810	11
12	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	7	68,533		4.07	6,198	12
13	27	EMP. BEN.- CFO (NON-OWNER	WGHTD. AVG. HOURS	40	9	27,736		3.13	2,172	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	9	18,548		3.13	1,451	14
15	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	11	35,535		0.22	278	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 428,023	$		$ 30,360	25

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 01/01/17 Ending: 12/31/17

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 01/01/17 Ending: 12/31/17

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 01/01/17 Ending: 12/31/17

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 01/01/17 Ending: 12/31/17

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 01/01/17 Ending: 12/31/17

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MB Financial		X	Mortgage Payable			$	$ 5,760,000			$ 294,600	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				801,925			48,090	6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,561,925			$ 342,690	9
	B. Non-Facility Related*											
10	Interest Income		X								(14,083)	10
11	Allocated from Dynamic Healthcare										1,388	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (12,695)	14
15	TOTALS (line 9+line14)						$	$ 6,561,925			$ 329,995	15

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

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

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

Facility Name & ID Number Sterling Pavilion # 0040436 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	31,000	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.)	$	32,406	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,406	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	30,500	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.)**	$	203	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.	$	32,109	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	27,281	8
	2013	27,856	9
	2014	28,393	10
	2015	29,963	11
	2016	29,885	12

2017 Accrual = $29,885 x 1.02 = $30,500 (Rounded)

Allocated from Dynamic Healthcare Consultants - $2521

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-16-402-001	Long Term Care Property	$ 28,293.36	$ 28,293.36
2.	11-16-402-013	Long Term Care Property	$ 1,591.30	$ 1,591.30
3.	10-23-404-059-0000	Allocated - Dynamic HC	$ 37,430.03	$ 2,784.48
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 67,314.69	$ 32,669.14

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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) 282-6300 FAX #: (847) 282-6301

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation 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: 01/01/17 Ending: 12/31/17

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 48,888	1
2	Sterling Building			100,000	2
3	TOTALS			$ 148,888	3

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121			1974	$ 6,052,408	$ 147,067	35	$ 172,926	$ 25,859	$ 3,806,695	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			33,627	12
13	Various			1997	33,822		20	(187)	(187)	33,178	13
14	Various			1998	35,361		20	1,768	1,768	35,228	14
15	Various			1999	47,068		20	2,321	2,321	44,376	15
16	Various			2000	11,922		20	596	596	10,360	16
17	Various			2001	21,256		20	1,063	1,063	17,607	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	25,690	21
22	Various			2006	19,001		20			19,001	22
23	Various			2007	20,058		20	661	661	16,193	23
24	Various			2008	27,237		20	1,647	1,647	26,404	24
25	Various			2009	29,407		20	754	754	6,080	25
26	Various			2010	5,936		20	152	152	1,167	26
27	Various			2011	18,507		20	791	791	4,893	27
28	Various			2012	339,689		20	16,984	16,984	86,338	28
29	Various			2013	223,201		20	15,695	15,695	70,403	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

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		33,000	846		943	97	22,943	68
69	Financial Statement Depreciation			146,767			(146,767)		69
70	TOTAL (lines 4 thru 69)		$ 7,195,971	$ 294,680		$ 216,355	$ (78,325)	$ 4,477,298	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,195,971	$ 294,680		$ 216,355	$ (78,325)	$ 4,477,298	1
2	Fire Systems	2014	2,820		20	403	403	1,611	2
3	Flooring Work	2014	3,504		20	90	90	356	3
4	Security System	2014	2,550		20	364	364	1,427	4
5	Electrical Work	2014	2,500		20	64	64	243	5
6	30 Cameras	2014	6,750		20	964	964	3,616	6
7	Boiler Room Work	2014	26,160		20	671	671	2,432	7
8	Windows	2014	2,527		20	65	65	235	8
9	Rtu Equipment	2014	15,911		20	1,591	1,591	5,304	9
10	Plumbing And Piping	2014	11,105		20	285	285	937	10
11	Plumbing Work / Remodeling	2015	5,222		20	261	261	762	11
12	Remodeling - Tile & Brickwork In Kitchen	2015	5,987		20	299	299	848	12
13	Cameras	2015	4,255		20	213	213	603	13
14	Bathroom Remodel-Pipe Cover, Shower Rom Toilet Flange	2015	3,721		20	186	186	527	14
15	Bathroom - Install Sink/Faucet, Floor, Lighting Work	2015	7,253		20	363	363	937	15
16	Boiler - Installed Pump 115V Inline Br 2-1/2" Kit	2016	2,878		20	82	82	130	16
17	Video Monitor System	2016	3,227		20	645	645	1,129	17
18	Install New Wall Flashing	2016	3,002		20	150	150	263	18
19	Install New Door Holders For Security System	2016	2,990		20	150	150	224	19
20	6" Sewer Pipe - Install Cipp Liner To Fix Hole	2017	4,490		20	32	32	32	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)		$ 7,312,822	$ 294,680		$ 223,233	$ (71,447)	$ 4,498,913	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,312,822	$ 294,680		$ 223,233	$ (71,447)	$ 4,498,913	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)		$ 7,312,822	$ 294,680		$ 223,233	$ (71,447)	$ 4,498,913	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,312,822	$ 294,680		$ 223,233	$ (71,447)	$ 4,498,913	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)		$ 7,312,822	$ 294,680		$ 223,233	$ (71,447)	$ 4,498,913	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,312,822	$ 294,680		$ 223,233	$ (71,447)	$ 4,498,913	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)		$ 7,312,822	$ 294,680		$ 223,233	$ (71,447)	$ 4,498,913	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: 01/01/17 Ending: 12/31/17

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	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.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 from Dynamic Healthcare Consultants	1993	33,000	846	35	943	97	22,943	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)		$ 33,000	$ 846		$ 943	$ 97	$ 22,943	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 33,000	$ 846		$ 943	$ 97	$ 22,943	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
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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)		$ 33,000	$ 846		$ 943	$ 97	$ 22,943	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: 01/01/17 Ending: 12/31/17

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	$ 470,614	$ 293	$ 66,699	$ 66,406	10	$ 414,417	71
72	Current Year Purchases	13,205		2,186	2,186	10	2,186	72
73	Fully Depreciated Assets	748,932		24	24	10	748,859	73
74								74
75	TOTALS	$ 1,232,751	$ 293	$ 68,909	$ 68,616		$ 1,165,462	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 from Dynamic Healthcare		22,023	1,127	926	(201)	5	17,533	78
79										79
80	TOTALS			$ 72,449	$ 1,127	$ 926	$ (201)		$ 67,959	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)	$ 8,766,910	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 296,100	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 293,068	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,032)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,732,334	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	$ 112,546	86
87	Land - 2004 - 1900	4,235			87
88					88
89					89
90					90
91	TOTALS	$ 260,543	$ 6,572	$ 112,546	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.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 19,179 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 from Dynamic Healthcare			9,745	18
19					19
20					20
21	TOTAL		$ 741	$ 18,637	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.

Facility Name & ID Number Sterling Pavilion # 0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number Sterling Pavilion

STATE OF ILLINOIS
0040436 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 232,340	$		$ 232,340	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			34,437			34,437	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			354,648			354,648	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				168,967		168,967	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					24,359	10,048		34,407	13
14	TOTAL			$		$ 645,784	$ 179,015		$ 824,799	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.

STATE OF ILLINOIS

Facility Name & ID Number Sterling Pavilion # 0040436 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/17 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,125	$ 30,608	1
2	Cash-Patient Deposits	66,225	66,225	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,177,785	1,177,785	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,974	90,974	6
7	Other Prepaid Expenses	90,076	90,076	7
8	Accounts Receivable (owners or related parties)		1,632,051	8
9	Other(specify): See Attached Schedule	49,065	75,312	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,480,250	$ 3,163,031	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	1,482,171	1,482,171	15
16	Equipment, at Historical Cost	958,842	1,209,296	16
17	Accumulated Depreciation (book methods)	(1,660,968)	(5,627,236)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	254,682	51,061	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,034,727	$ 3,211,429	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,514,977	$ 6,374,460	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 440,041	$ 440,042	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,225	66,225	28
29	Short-Term Notes Payable	801,925	801,925	29
30	Accrued Salaries Payable	196,123	196,123	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,275	5,275	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,500	30,500	32
33	Accrued Interest Payable	1,755	1,755	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	16,606	20,806	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,558,450	$ 1,562,651	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	See Attached Schedule	1,956,051	1,956,051	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,956,051	$ 7,716,051	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,514,501	$ 9,278,702	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (999,524)	$ (2,904,242)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,514,977	$ 6,374,460	48

***(See instructions.)**

Facility Name & ID Number Sterling Pavilion **#** 0040436 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (388,880)	1
2	Restatements (describe):		2
3	Rounding	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (388,876)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(610,648)	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)**	$ (610,648)	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)**	$ (999,524)	24 *

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

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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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,886,467	1
2	Discounts and Allowances for all Levels	(769,394)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,117,073	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,018,900	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,018,900	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	165,464	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,793	19
20	Radiology and X-Ray	3,830	20
21	Other Medical Services	10,399	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 190,486	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,083	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,083	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	54,020	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 54,020	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,394,562	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,053,813	31
32	Health Care	2,070,025	32
33	General Administration	2,100,722	33
	B. Capital Expense		
34	Ownership	748,371	34
	C. Ancillary Expense		
35	Special Cost Centers	849,208	35
36	Provider Participation Fee	183,071	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,005,210	40
41	**Income before Income Taxes (line 30 minus line 40)****	(610,648)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (610,648)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,215,263	44
45	Private Pay - Net Inpatient Revenue	858,090	45
46	Medicare - Net Inpatient Revenue	211,774	46
47	Other-(specify) Medicare Replacement	71,444	47
48	Other-(specify) Ins./Mgd Care/Hospice	760,502	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,117,073	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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,028	2,148	$ 69,835	$ 32.51	1
2	Assistant Director of Nursing	1,995	2,035	58,547	28.78	2
3	Registered Nurses	6,325	6,701	189,561	28.29	3
4	Licensed Practical Nurses	21,438	23,097	553,039	23.94	4
5	CNAs & Orderlies	44,000	47,153	613,828	13.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,559	7,702	129,702	16.84	8
9	Activity Director	1,952	2,080	27,532	13.24	9
10	Activity Assistants	11,013	11,670	115,654	9.91	10
11	Social Service Workers	5,660	6,060	114,036	18.82	11
12	Dietician					12
13	Food Service Supervisor	2,024	2,176	34,996	16.08	13
14	Head Cook	4,072	4,456	45,691	10.25	14
15	Cook Helpers/Assistants	14,475	15,502	155,204	10.01	15
16	Dishwashers					16
17	Maintenance Workers	5,231	5,657	80,772	14.28	17
18	Housekeepers	13,376	14,933	160,436	10.74	18
19	Laundry	7,992	8,426	81,314	9.65	19
20	Administrator	1,840	2,160	95,224	44.09	20
21	Assistant Administrator	1,243	1,351	42,000	31.09	21
22	Other Administrative					22
23	Office Manager	858	886	22,568	25.47	23
24	Clerical	5,570	6,103	112,154	18.38	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	1,724	1,908	25,865	13.56	31
32	Other Health Care(specify)					32
33	Other(specify)	1,001	1,010	20,209	20.00	33
34	TOTAL (lines 1 - 33)	160,375	173,214	$ 2,748,167 *	$ 15.87	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	146	$ 8,340	01-03	35
36	Medical Director	Monthly	15,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	38,000	10-03	38
39	Pharmacist Consultant	Per Bed	7,641	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	68	4,489	12-03	45
46	Other(specify)				46
47	Psychiatric	Monthly	6,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)	214	$ 80,070		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rhonda Reed	Administrator	0	$ 95,224
Fred Aaron	Assistant Admin	23.8%	42,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 137,223

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum	Accounting	$ 32,297
Singer Networks	Data Processing	283
Ability Network	Data Processing	22
CDW Corporation	Data Processing	1,038
Blymas Inc.	Tax Credit Services	2,419
See Attached	Legal Fees	24,223
Winter, Kloman, Moter & Repp	Accounting	749
Personnel Planners	Unemployment Consulting	1,086
Terrill Consulting Services	Reimb/Compliance Consulting	10,129
Cooper Valuation Group	Valuation Services	5,400
See Supplemental Schedule		528,950
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 606,596

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,575
Unemployment Compensation Insurance	29,044
FICA Taxes	206,186
Employee Health Insurance	139,016
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	1,456
Other Employee Benefits	14,648
TOTAL (agree to Schedule V, line 22, col.8)	$ 448,925

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,404
Health Care Worker Background Check	2,913
(Indicate # of checks performed 291)	
Patient Background Checks	
Dues & Subscriptions	11,497
Licenses & Permits	10,093
Allocated from Dynamic Healthcare	2,906
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,813

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,308
Allocated from Dynamic Healthcare	270
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,578

* Attach copy of IMRF notifications

**See instructions.

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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 - $17,400**

(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. $ **392** 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. $ **183,071**
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. $ 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