

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,766	6,393	6,094	15,253	8
9	SNF/PED					9
10	ICF	12,814	2,049	1,169	16,032	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,580	8,442	7,263	31,285	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.84%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 04/01/1993

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/01/1993 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 121 and days of care provided 6,089

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

Sterling Pavilion

0040436

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	25,726	7,145	303,666	336,537		336,537		336,537		1
2	Food Purchase		170,423		170,423		170,423	(457)	169,966		2
3	Housekeeping	9,008	3,934	133,884	146,826		146,826		146,826		3
4	Laundry	7,869	4,494	90,028	102,391		102,391		102,391		4
5	Heat and Other Utilities			128,465	128,465		128,465	816	129,281		5
6	Maintenance	95,311	48,061	42,796	186,168		186,168	51,419	237,587		6
7	Other (specify):*							660	660		7
8	TOTAL General Services	137,914	234,057	698,839	1,070,810		1,070,810	52,438	1,123,248		8
	B. Health Care and Programs										
9	Medical Director			11,100	11,100		11,100		11,100		9
10	Nursing and Medical Records	1,522,786	88,019	12,547	1,623,352		1,623,352		1,623,352		10
10a	Therapy		6,529		6,529		6,529		6,529		10a
11	Activities	134,195	3,918		138,113		138,113		138,113		11
12	Social Services	63,403		5,216	68,619		68,619		68,619		12
13	CNA Training										13
14	Program Transportation			180	180		180		180		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,720,384	98,466	29,043	1,847,893		1,847,893		1,847,893		16
	C. General Administration										
17	Administrative	133,666			133,666		133,666	79,886	213,552		17
18	Directors Fees										18
19	Professional Services			585,554	585,554	(350)	585,204	(506,337)	78,868		19
20	Dues, Fees, Subscriptions & Promotions			107,023	107,023		107,023	(81,398)	25,625		20
21	Clerical & General Office Expenses	65,042	2,934	329,591	397,567		397,567	(221,226)	176,341		21
22	Employee Benefits & Payroll Taxes			366,378	366,378		366,378		366,378		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,505	5,505		5,505	745	6,250		24
25	Other Admin. Staff Transportation			15,692	15,692		15,692	2,329	18,021		25
26	Insurance-Prop.Liab.Malpractice			120,772	120,772		120,772	(925)	119,847		26
27	Other (specify):*							28,421	28,421		27
28	TOTAL General Administration	198,708	2,934	1,530,515	1,732,157	(350)	1,731,807	(698,504)	1,033,303		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,057,006	335,457	2,258,397	4,650,860	(350)	4,650,510	(646,066)	4,004,444		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:

01/01/14

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			151,405	151,405		151,405	161,096	312,501			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,135	89,135		89,135	193,667	282,802			32
33	Real Estate Taxes			27,856	27,856	350	28,206	26,286	54,492			33
34	Rent-Facility & Grounds			451,200	451,200		451,200	(451,200)				34
35	Rent-Equipment & Vehicles			8,994	8,994		8,994	7,536	16,530			35
36	Other (specify):*											36
37	TOTAL Ownership			728,590	728,590	350	728,940	(62,615)	666,324			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		183,498	708,877	892,375		892,375		892,375			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			219,175	219,175		219,175		219,175			42
43	Other (specify):*	37,990			37,990		37,990	(37,990)				43
44	TOTAL Special Cost Centers	37,990	183,498	928,052	1,149,540		1,149,540	(37,990)	1,111,550			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,094,996	518,955	3,915,039	6,528,990		6,528,990	(746,671)	5,782,319			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

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,405	30		9
10	Interest and Other Investment Income	(5,089)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(457)	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	(13,386)	21		18
19	Entertainment				19
20	Contributions	(3,099)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(87,000)	21		24
25	Fund Raising, Advertising and Promotional	(73,057)	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	(282,718)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (452,401)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(294,270)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (294,270)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (746,671)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Sterling Pavilion

ID# 0040436

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Sequestration Expense	\$ (47,183)	21	1
2	Bank Charges	(13,204)	21	2
3	Intercompany Interest	(51,465)	32	3
4	PPA - Office Expenses	(8,045)	21	4
5	PPA - Various write-off accounts	(110,754)	21	5
6	PAC Dues	(7,314)	20	6
7	Non-Allowable Legal	(11,681)	19	7
8	Additional R&M	41,715	06	8
9	Marketing Salary	(37,990)	43	9
10	Building Co. - Amortization	(2,542)	31	10
11	Building Co. - Bank Fees	(1,662)	21	11
12	Building Co. - Professional and Legal Fees	(21,925)	19	12
13	Building Co.- License and Fees	(250)	20	13
14	Non-Care Depreciation	(6,572)	30	14
15	Non-Allowable Travel	(347)	25	15
16	HUD Expense	(3,500)	19	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(282,718)	49

Sterling Pavilion

ID# 0040436

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sterling Pavilion# 0040436

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(457)											(457)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			816									816	5
6	Maintenance	41,715		4,851	4,853								51,419	6
7	Other (specify):*			157		503							660	7
8	TOTAL General Services	41,258		5,824	4,853	503							52,438	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative				79,886								79,886	17
18	Directors Fees													18
19	Professional Services	(37,106)	21,925	(491,156)									(506,337)	19
20	Fees, Subscriptions & Promotions	(83,720)	250	2,072									(81,398)	20
21	Clerical & General Office Expenses	(281,234)	1,662	51,569	6,777								(221,226)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			745									745	24
25	Other Admin. Staff Transportation	(347)		2,676									2,329	25
26	Insurance-Prop.Liab.Malpractice			(925)									(925)	26
27	Other (specify):*			9,163		19,258							28,421	27
28	TOTAL General Administration	(402,406)	23,837	(425,856)	86,663	19,258							(698,504)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(361,148)	23,837	(420,032)	91,516	19,761							(646,066)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	5,833	153,639	1,624									161,096	30
31	Amortization of Pre-Op. & Org.	(2,542)	2,542											31
32	Interest	(56,554)	248,828	1,393									193,667	32
33	Real Estate Taxes		23,495	2,791									26,286	33
34	Rent-Facility & Grounds		(451,200)										(451,200)	34
35	Rent-Equipment & Vehicles			7,536									7,536	35
36	Other (specify):*													36
37	TOTAL Ownership	(53,263)	(22,696)	13,344									(62,615)	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):*	(37,990)											(37,990)	43
44	TOTAL Special Cost Centers	(37,990)											(37,990)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(452,401)	1,141	(406,688)	91,516	19,761							(746,671)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 451,200	Sterling Pavilion Building, LLC	100.00%	\$	\$ (451,200)	1
2	V	33 Real Estate Taxes		Sterling Pavilion Building, LLC	100.00%	23,495	23,495	2
3	V	32 Interest Expense-MB Loan		Sterling Pavilion Building, LLC	100.00%	628	628	3
4	V	32 Interest Expense-Mortgage		Sterling Pavilion Building, LLC	100.00%	248,200	248,200	4
5	V	30 Depreciation		Sterling Pavilion Building, LLC	100.00%	153,639	153,639	5
6	V	31 Amortization		Sterling Pavilion Building, LLC	100.00%	2,542	2,542	6
7	V	21 Bank Fees		Sterling Pavilion Building, LLC	100.00%	1,662	1,662	7
8	V	20 License and Fees		Sterling Pavilion Building, LLC	100.00%	250	250	8
9	V	19 Professional and Legal Fees		Sterling Pavilion Building, LLC	100.00%	21,925	21,925	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 451,200			\$ 452,341	\$ * 1,141	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 816	\$	816	15
16	V	6 REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	4,851		4,851	16
17	V	7 EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	157		157	17
18	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	694		694	18
19	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	2,072		2,072	19
20	V	21 CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	51,569		51,569	20
21	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	745		745	21
22	V	25 AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	2,676		2,676	22
23	V	26 INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	(925)		(925)	23
24	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	9,163		9,163	24
25	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	1,624		1,624	25
26	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	1,393		1,393	26
27	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	2,791		2,791	27
28	V	19 REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%	350		350	28
29	V	35 AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	7,481		7,481	29
30	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	55		55	30
31	V								31
32	V	19 HOME OFFICE	492,200	DYNAMIC HEALTH CARE CONS.	100.00%			(492,200)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 492,200			\$ 85,512	\$ *	(406,688)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 4,853	\$	4,853	15
16	V	17 ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	14,560		14,560	16
17	V	17 ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	16,372		16,372	17
18	V	17 ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	2,200		2,200	18
19	V	17 ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%				19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%				20
21	V	17 ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%				21
22	V	17 ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	12,289		12,289	22
23	V	17 ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%				23
24	V	17 ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	9,291		9,291	24
25	V	17 ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	10,615		10,615	25
26	V	17 ADMIN. CMP. - CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	14,559		14,559	26
27	V	21 CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	6,336		6,336	27
28	V	21 CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	441		441	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		\$			\$ 91,516	\$ *	91,516	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 503	\$	503	15
16	V	27 EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	837		837	16
17	V	27 EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,179		1,179	17
18	V	27 EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	7,526		7,526	18
19	V	27 EMP. BEN.- D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%				19
20	V	27 EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%				20
21	V	27 EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%				21
22	V	27 EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%	879		879	22
23	V	27 EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%				23
24	V	27 EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	2,253		2,253	24
25	V	27 EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	3,367		3,367	25
26	V	27 EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	1,765		1,765	26
27	V	27 EMP. BEN.- S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,226		1,226	27
28	V	27 EMP. BEN.- E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	226		226	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 19,761	\$ *	19,761	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Sterling Pavilion

0040436

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	22.231%	BRIDGEVIEW HEALTH CARE CENTER, LTD.	BRIDGEVIEW	STERLING BUILDING LLC		BUILDING CO.	1
2	FRED L. AARON	23.802%	GROSSE POINTE MANOR, L.L.C.	NILES	DYNAMIC HEALTH CARE	SKOKIE	BOOKEEPING/CONSULT	2
3	MARSHALL A. MAUER	8.264%	OTTAWA PAVILION, LTD.	OTTAWA				3
4	ABRAHAM J. STERN	4.959%	PARK RIDGE CARE CENTER, LTD.	PARK RIDGE				4
5	MIRIAM LATINIK	4.132%	WARREN PARK HEALTH AND LIVING CENTER,LLC	CHICAGO				5
6	SHIMON GOLDSTEIN	4.132%	WATERFRONT TERRACE, INC.	CHICAGO				6
7	SUSAN ALTER	4.917%	WILLOW CREST NURSING PAVILION, LTD.	SANDWICH				7
8	SYLVIA AARON	1.810%	WINDMILL NURSING PAVILION, LTD.	SOUTH HOLLAND				8
9	CHANI MAUER	4.240%	WOODBRIIDGE NURSING PAVILION, LTD.	CHICAGO				9
10	DENNIS NEHMER	0.393%	WOODBRIIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG (GALESBURG					10
11	DIANIA KUFTA	0.393%	WOODBRIIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO (SLJ GENESEO					11
12	ESTHER MARYLES	4.240%	WOODBRIIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC (SLF PONTIAC					12
13	SUE KOPLIN HARAMARAS	0.393%	RIVER NORTH OF BRADELY HEALTH & REHAB	BRADLEY				13
14	SUSAN L. STERN	4.959%						14
15	FRANCES MAUER	8.265%						15
16	TODD ANDREW STERN TRUST DTD 10/31/01	0.826%						16
17	MICHAEL LOVALLO, TRUSTEE FOR EVAN	0.826%						17
18	SHARON AARON	0.393%						18
19	JONATHAN BRYAN STERN TRUST DTD	0.826%						19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/14

Ending:

12/31/14

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: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marshall Mauer	Owner	Administrative	8.26%	See attached	2.91	5.82%	Alloc. Salary	\$ 14,560	17-07	1
2	Maury Aaron	Owner	Administrative	22.23%	See attached	3.27	6.54%	Alloc. Salary	16,372	17-07	2
3	Sharon Aaron	Owner	Clerical	0.39%	See attached	2.91	7.27%	Alloc. Salary	6,336	21-07	3
4	Dennis Nehmer	Owner	Maintenance	0.39%	See attached	3.27	8.18%	Alloc. Salary	4,853	06-07	4
5	Diania Kufra	Owner	Administrative	0.39%	See attached	4.09	8.18%	Alloc. Salary	12,289	17-07	5
6	Fred Aaron	Owner	Administrative	23.80%	See attached	9	20.00%	Sal./Alloc. Salary	37,200	17-01, 17-07	6
7	Esther Maryles	Owner	Clerical	4.24%	See attached	0.2	0.71%	Alloc. Salary	441	21-07	7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 92,051		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: 01/01/14 Ending: 12/31/14

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

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

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

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

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	452,396	14	\$ 11,795	\$ 31,285	\$ 816	1	
2	6	REPAIRS & MAINT.	PATIENT DAYS	452,396	14	70,149	38,885	31,285	4,851	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	452,396	14	2,266	31,285	157	3	
4	19	PROFESSIONAL FEES	PATIENT DAYS	452,396	14	10,039	31,285	694	4	
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	452,396	14	29,965	31,285	2,072	5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	452,396	14	745,706	528,878	31,285	51,569	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	452,396	14	10,766	31,285	745	7	
8	25	AUTO EXP.	PATIENT DAYS	452,396	14	38,698	31,285	2,676	8	
9	26	INSURANCE	PATIENT DAYS	452,396	14	(13,379)	31,285	(925)	9	
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	452,396	14	132,506	31,285	9,163	10	
11	30	DEPRECIATION	PATIENT DAYS	452,396	14	23,478	31,285	1,624	11	
12	32	INTEREST	PATIENT DAYS	452,396	14	20,148	31,285	1,393	12	
13	33	REAL ESTATE TAXES	PATIENT DAYS	452,396	14	40,366	31,285	2,791	13	
14	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	452,396	14	5,056	31,285	350	14	
15	35	AUTO RENTAL	PATIENT DAYS	452,396	14	108,178	31,285	7,481	15	
16	35	EQUIPMENT RENTAL	PATIENT DAYS	452,396	14	802	31,285	55	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,236,539	\$ 567,763	\$ 85,512	25	

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	59,284	59,284	3.27	4,853	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	2.91	14,560	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	200,000	200,000	3.27	16,372	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	11,000	11,000	9.00	2,200	4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	60,271	60,271	-		5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	103,196	103,196	-		6
7	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	4	76,737	76,737	-		7
8	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	9	150,258	150,258	4.09	12,289	8
9	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		9
10	17	ADMIN. CMP. - V. DAVIS (NON	WGHTD. AVG. HOURS	40	11	127,632	127,632	2.91	9,291	10
11	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	9	129,197	129,197	3.68	10,615	11
12	17	ADMIN. CMP. - CFO (NON-OW	WGHTD. AVG. HOURS	40	11	200,000	200,000	2.91	14,559	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	87,119	87,119	2.91	6,336	13
14	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	12	60,541	60,541	0.20	441	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,477,235	\$ 1,477,235		\$ 91,516	25

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	40	9	6,150		3.27	503	1
2	27	EMP. BEN.- M. MAUER	40	11	11,498		2.91	837	2
3	27	EMP. BEN.- M. AARON	40	9	14,402		3.27	1,179	3
4	27	EMP. BEN.- F. AARON	45	5	37,628		9.00	7,526	4
5	27	EMP. BEN.- D. AARON	40	3	4,909		-		5
6	27	EMP. BEN.- S. GOLDSTEIN	40	2	37,033		-		6
7	27	EMP. BEN.- S. HARAMARAS	30	4	25,836		-		7
8	27	EMP. BEN.- D. KUFTA	50	9	10,754		4.09	879	8
9	27	EMP. BEN.- H. ALTER	40	1	1,085		-		9
10	27	EMP. BEN.-V. DAVIS (NON-OW)	40	11	30,956		2.91	2,253	10
11	27	EMP. BEN.- NON-OWNER	45	9	40,985		3.68	3,367	11
12	27	EMP. BEN.- CFO (NON-OWNER)	40	11	24,244		2.91	1,765	12
13	27	EMP. BEN. - S. AARON	40	11	16,859		2.91	1,226	13
14	27	EMP. BEN. - E. MARYLES	28	12	30,999		0.20	226	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 293,338	\$		\$ 19,761	25

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/14

Ending:

12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8	MB Financial		X				\$	\$			\$ 628					
9																
10																
11																
12																
13																
14	TOTAL Working Capital										628					
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2013 report.		\$	4,505		1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	30,647		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	26,142		3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	28,000		4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	350		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.		\$	54,492		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>27,761</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>28,029</u>	9																
	2011	<u>27,535</u>	10																
	2012	<u>27,281</u>	11																
	2013	<u>27,856</u>	12																
2014 Accrual = \$27,856 x 1.01 = \$28,000 (Rounded)																			
*Beginning Accrual Adjusted																			
Allocated from Dynamic - \$2,791																			

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.

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.**

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Sterling Pavilion

0040436 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,000 B. General Construction Type: Exterior Brick Frame Steele/Concrete Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	121		1974	\$ 6,052,408	\$ 147,067	35	\$ 172,926	\$ 25,859	\$ 3,287,917	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	125	125	6,356	10
11	Various		1995	13,538		20	674	674	13,076	11
12	Various		1996	33,635		20	1,682	1,682	30,748	12
13	Various		1997	33,822		20	3,254	3,254	56,686	13
14	Various		1998	35,361		20	4,321	4,321	70,990	14
15	Various		1999	47,068		20	3,857	3,857	60,573	15
16	Various		2000	11,922		20	596	596	8,571	16
17	Various		2001	21,256		20	1,063	1,063	14,418	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	2,314	2,314	53,564	20
21	Various		2005	27,344		20	1,354	1,354	24,299	21
22	Various		2006	19,001		20	1,022	1,022	17,675	22
23	Various		2007	20,058		20	1,430	1,430	12,672	23
24	Various		2008	27,237		20	1,647	1,647	21,463	24
25	Various		2009	29,407		20	754	754	3,818	25
26	Various		2010	5,936		20	152	152	710	26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sterling Pavilion

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			30,677	787	876	89	18,698	68
69				151,405		(151,405)		69
70			\$ 6,612,251	\$ 299,259		\$ 198,047	\$ (101,212)	\$ 3,845,894 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:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,612,251	\$ 299,259		\$ 198,047	\$ (101,212)	\$ 3,845,894	1
2	Water System	2011	2,657		20	68	68	258	2
3	Heating System	2011	3,979		20	102	102	344	3
4	Electrical Wiring	2011	2,721		20	70	70	224	4
5	Hot Water Pump Replacement	2011	4,895		20	126	126	382	5
6	Bathroom- Floor, Wall, Ceiling, Faucet	2011	4,255		20	426	426	1,312	6
7	100 Wing - Carpet-Conf Room, Bus Office, Admin Office, Hall	2012	8,151		20	408	408	849	7
8	100 Wing - Front/Rear Entry Wander Guard	2012	3,246		20	162	162	338	8
9	100 Wing - Front Office Drywall, Lobby Wallcovering	2012	2,606		20	130	130	271	9
10	200 Wing - Wall Heaters-Rooms 201-227	2012	15,260		20	763	763	1,590	10
11	200 Wing - Over Mirror And Room Lighting-Rms 201-227	2012	12,480		20	624	624	1,300	11
12	200 Wing - Window Sills & Sink Counter Tops - Rms 201-227	2012	21,929		20	1,096	1,096	2,284	12
13	200 Wing - Window Treatments-Rms 201-227	2012	13,480		20	674	674	1,404	13
14	200 Wing - Handrail, Crashrail, End Cap, Corner Guard	2012	34,678		20	1,734	1,734	3,612	14
15	200 Wing - Flooring & Install-Rms 201-227	2012	57,859		20	2,893	2,893	6,027	15
16	200 Wing - Bathroom Tile Install-Rms 201-227	2012	14,241		20	712	712	1,483	16
17	200 Wing - Wallcovering Install	2012	16,383		20	819	819	1,707	17
18	200 Wing - Curtain Tracks	2012	3,584		20	179	179	373	18
19	200 Wing - Electrical Work	2012	13,167		20	658	658	1,372	19
20	200 Wing - Undercounter Lavatory Sink	2012	2,807		20	140	140	292	20
21	300 Wing - Nsg Station Cabinets	2012	8,924		20	446	446	930	21
22	300 Wing - Dementia Day Room-Wallcovering,Cabinets,Handrails	2012	9,619		20	481	481	1,002	22
23	300 Wing - Hallway-Carpet, Handrails, Electrical	2012	10,077		20	504	504	1,050	23
24	Dining Room Wallcovering	2012	5,885		20	294	294	613	24
25	Therapy Room - Doors, Wallcovering, Wall Heater, Lighting, Floo	2012	34,468		20	1,723	1,723	3,590	25
26	Security Cameras & Monitors	2012	4,415		20	221	221	460	26
27	Entrance Corridor Flooring	2012	31,723		20	1,586	1,586	3,304	27
28	Desk Audit	2012	9,710		20	486	486	1,457	28
29	Desk Audit	2012	4,997		20	250	250	750	29
30	Heating Pump In And Furnace	2013	7,720		20	198	198	305	30
31	Flooring Materials	2013	18,272		20	3,654	3,654	5,786	31
32	Construction Work On Handrails	2013	7,228		20	185	185	301	32
33	Corner Guards For Wall & Door Protection	2013	3,785		20	757	757	1,199	33
34	TOTAL (lines 1 thru 33)		\$ 7,007,453	\$ 299,259		\$ 220,617	\$ (78,642)	\$ 3,892,064	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:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,007,453	\$ 299,259		\$ 220,617	\$ (78,642)	\$ 3,892,064	1
2	Heat Pumps	2013	7,452		20	191	191	295	2
3	Install Doors In Dining Room Storage, Office South Wall	2013	5,302		20	136	136	210	3
4	Remove And Install Front & Rear Doors	2013	5,990		20	154	154	237	4
5	Interior Signage	2013	6,565		20	438	438	693	5
6	Drywall	2013	6,000		20	154	154	237	6
7	Replaced Door & Frames In Boiler And Laundry Room	2013	7,265		20	186	186	287	7
8	Hard Wire Existing Em Lights, Change Hallway Light Over Gene	2013	3,285		20	84	84	123	8
9	Office Wallcoverings	2013	2,724		20	70	70	102	9
10	Replaced Door & Frames Of Courtyard Entrances, Install Front W	2013	5,824		20	149	149	218	10
11	Wallpaper Main Office	2013	2,601		20	67	67	92	11
12	Remove And Replace Front Reception Windows, East Wall	2013	3,206		20	82	82	113	12
13	Window Treatments	2013	9,926		20	1,985	1,985	2,647	13
14	Plumbing & Pipe Work For B Wing Water Heater	2013	7,928		20	203	203	263	14
15	Drywall And Prime Front Office, Entryway, Front Lobby, Cafeter	2013	4,300		20	110	110	142	15
16	Fixtures, Lighting Accessories In Private Dining, Lighting Sconces	2013	6,359		20	1,272	1,272	1,696	16
17	Electric Stand	2013	2,757		20	551	551	781	17
18	Wall Protection- Pt/Ot Room, Alzheimer Lounge	2013	4,451		20	114	114	147	18
19	Floor Primer, Glue Down Carpet	2013	3,870		20	774	774	967	19
20	Drywall & Paint 4 Rooms	2013	6,400		20	164	164	198	20
21	Wall Protection	2013	4,551		20	117	117	141	21
22	Remove And Replace Parking Lot Pavement	2013	3,000		20	77	77	93	22
23	200 Wing - Ceiling Lights & Tile, Wallpaper Install	2013	21,943		20	1,097	1,097	1,920	23
24	300 Wing - Dementia Area Cabinets, Corridor Handrails	2013	12,185		20	609	609	1,066	24
25	Therapy Remodel - Cabinets, Tile & Wallpaper Install	2013	3,673		20	184	184	321	25
26	200 Corridor Window Treatments & Wallcovering	2013	38,639		20	1,932	1,932	2,737	26
27	Fire Systems- Run Cables For Cameras/Materials	2014	2,820		20	403	403	403	27
28	Flooring Materials	2014	3,504		20	86	86	86	28
29	Security System- Monitor, Camera	2014	2,550		20	334	334	334	29
30	Electrical Work- Removed Breakers On Panels	2014	2,500		20	51	51	51	30
31	Installed 30 Cameras	2014	6,750		20	723	723	723	31
32	Boiler Room Equipment- Bottom Connection/Stem/Expansion Tan	2014	26,160		20	419	419	419	32
33	New Windows Installed In Phone Room	2014	2,527		20	41	41	41	33
34	TOTAL (lines 1 thru 33)		\$ 7,240,459	\$ 299,259		\$ 233,574	\$ (65,685)	\$ 3,909,847	34

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

Facility Name & ID Number Sterling Pavilion

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		\$ 7,240,459	\$ 299,259		\$ 233,574	\$ (65,685)	\$ 3,909,847	1
2	Rtu And Materials On Rooftop	2014	15,911		20	530	530	530	2
3	Install New Hot Water Boiler	2014	11,105		20	83	83	83	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)		\$ 7,267,474	\$ 299,259		\$ 234,188	\$ (65,071)	\$ 3,910,460	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:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,267,474	\$ 299,259		\$ 234,188	\$ (65,071)	\$ 3,910,460	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)	\$ 7,267,474	\$ 299,259		\$ 234,188	\$ (65,071)	\$ 3,910,460	34

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

Facility Name & ID Number Sterling Pavilion

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 12E, Carried Forward			\$		\$				\$		\$		\$		1
2	Buildings:															2
3																3
4																4
5																5
6																6
7																7
8	Leasehold Improvements															8
9																9
10																10
11																11
12																12
13																13
14																14
15																15
16																16
17																17
18																18
19																19
20																20
21																21
22																22
23																23
24																24
25																25
26																26
27																27
28																28
29																29
30																30
31																31
32																32
33																33
34	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

XI. OWNERSHIP COSTS (continued)

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

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

01/01/14

Ending:

12/31/14

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 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Dynamic	1993	30,677	787	20	876	89	18,698	3
4									4
5									5
6									6
7									7
8	Leasehold Information								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)		\$ 30,677	\$ 787		\$ 876	\$ 89	\$ 18,698	34

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

Facility Name & ID Number Sterling Pavilion

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 30,677	\$ 787		\$ 876	\$ 89	\$ 18,698		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)	\$ 30,677	\$ 787		\$ 876	\$ 89	\$ 18,698		34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 491,954	\$ 43	\$ 73,787	\$ 73,744	10	\$ 263,375	71
72	Current Year Purchases	19,070	446	1,796	1,350	10	1,796	72
73	Fully Depreciated Assets	678,661		32	32	10	678,593	73
74								74
75	TOTALS	\$ 1,189,685	\$ 489	\$ 75,615	\$ 75,126		\$ 943,764	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	2014	16,299	347	2,697	2,350	5	10,290	78
79										79
80	TOTALS			\$ 66,725	\$ 347	\$ 2,697	\$ 2,350		\$ 60,716	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)	\$ 8,672,772	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 300,095	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 312,500	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,405	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,914,940	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	\$ 256,308	\$ 6,572	\$ 92,533	86
87	Land - 2004	4,235			87
88					88
89					89
90					90
91	TOTALS	\$ 260,543	\$ 6,572	\$ 92,533	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: 01/01/14

Ending: 12/31/14

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,580

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	2014 Dodge Caravan	\$ 578.00	\$ 3,468	17
18	Allocated from Dynamic			7,481	18
19					19
20					20
21	TOTAL		\$ 578.00	\$ 10,949	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: 01/01/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	223,609	\$		\$	223,609	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				26,330				26,330	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				456,214				456,214	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					168,245			168,245	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						2,724	15,253			17,977	13
14	TOTAL			\$		\$	708,877	\$	183,498	\$	892,375	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.

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 142,400	\$ 204,389	1
2	Cash-Patient Deposits	78,942	78,942	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,718,824	1,718,824	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,117	83,117	6
7	Other Prepaid Expenses	8,110	8,110	7
8	Accounts Receivable (owners or related parties)		833,351	8
9	Other(specify):	48,617	380,577	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,080,010	\$ 3,307,310	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	1,454,396	1,454,396	15
16	Equipment, at Historical Cost	889,451	1,159,621	16
17	Accumulated Depreciation (book methods)	(1,440,047)	(4,965,114)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,498	6,498	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,498)	(6,498)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	254,713	58,718	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,158,513	\$ 3,803,758	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,238,523	\$ 7,111,068	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 585,181	\$ 585,180	26
27	Officer's Accounts Payable	62,500	62,500	27
28	Accounts Payable-Patient Deposits	78,942	78,942	28
29	Short-Term Notes Payable	798,647	798,647	29
30	Accrued Salaries Payable	231,106	231,106	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,625	12,625	31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,000	28,000	32
33	Accrued Interest Payable	9,525	9,525	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,554,648	1,554,648	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,361,174	\$ 3,361,173	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,700,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,700,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,361,174	\$ 9,061,173	46
47	TOTAL EQUITY(page 18, line 24)	\$ (122,651)	\$ (1,950,105)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,238,523	\$ 7,111,068	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (694,597)	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (694,599)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	571,948	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)	\$ 571,948	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)	\$ (122,651)	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,680,283	1
2	Discounts and Allowances for all Levels	(2,300,683)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,379,600	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,321,060	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,321,060	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	251,220	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,404	19
20	Radiology and X-Ray	9,286	20
21	Other Medical Services	9,461	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 311,371	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,089	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,089	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	83,818	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 83,818	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,100,938	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,070,810	31
32	Health Care	1,847,893	32
33	General Administration	1,732,157	33
B. Capital Expense			
34	Ownership	728,590	34
C. Ancillary Expense			
35	Special Cost Centers	930,365	35
36	Provider Participation Fee	219,175	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,528,990	40
41	Income before Income Taxes (line 30 minus line 40)**	571,948	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 571,948	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,267,424	44
45	Private Pay - Net Inpatient Revenue	1,354,373	45
46	Medicare - Net Inpatient Revenue	593,588	46
47	Other-(specify) Hospice	164,215	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,379,600	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.

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/14

Ending:

12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,043	2,203	\$ 72,341	\$ 32.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,168	10,793	291,103	26.97	3
4	Licensed Practical Nurses	18,789	19,733	429,714	21.78	4
5	CNAs & Orderlies	55,372	59,668	703,522	11.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,081	2,649	29,241	11.04	9
10	Activity Assistants	10,596	11,377	104,954	9.23	10
11	Social Service Workers	3,879	4,007	63,403	15.82	11
12	Dietician					12
13	Food Service Supervisor	374	417	7,495	17.97	13
14	Head Cook	557	588	5,613	9.55	14
15	Cook Helpers/Assistants	1,263	1,406	12,618	8.97	15
16	Dishwashers					16
17	Maintenance Workers	5,683	6,097	95,311	15.63	17
18	Housekeepers	891	972	9,008	9.27	18
19	Laundry	721	910	7,869	8.65	19
20	Administrator	2,005	2,189	98,666	45.07	20
21	Assistant Administrator					21
22	Other Administrative	437	437	35,000	80.09	22
23	Office Manager					23
24	Clerical	3,737	4,065	65,042	16.00	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	1,989	2,165	26,106	12.06	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,783	1,871	37,990	20.30	33
34	TOTAL (lines 1 - 33)	122,368	131,547	\$ 2,094,996 *	\$ 15.93	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 731	01-03	35
36	Medical Director	111	11,100	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	107	6,547	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	84	5,216	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	24	6,000	10-03	47
48	Outside Dietary		302,935	01-03	48
49	TOTAL (lines 35 - 48)	326	\$ 332,529		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Rhonda Reed	Administrator	0	\$ 98,666	Workers' Compensation Insurance	\$ 52,403	IDPH License Fee	\$	
Fred Aaron	Administrator	23.802%	35,000	Unemployment Compensation Insurance	43,076	Advertising: Employee Recruitment	5,899	
				FICA Taxes	157,361	Health Care Worker Background Check	2,220	
				Employee Health Insurance	94,999	(Indicate # of checks performed 222)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	5,985	
				Other Employee Benefits	18,538	Licenses & Permits	9,450	
						Allocated from Dynamic	2,072	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 133,666					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,626	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type	Amount		Line #	Amount	Amount		
Personnel Planners	Unemployment Consulting	\$ 1,499			\$	Out-of-State Travel		
Dynamic HC Consultants	Bookkeeping/Home Office	492,200				\$		
See Attached	Legal	19,184						
Frost, Ruttenberg & Rothblatt	Accounting	23,438				In-State Travel		
eHealth Solutions	Data Processing	4,204						
Casamba	Data Processing	3,900						
Health Data Systems, Inc.	Data Processing	4,712				Seminar Expense		
Dynamic HC Consultants	Data Processing	29,796				5,505		
National Datacare Corporation	Data Processing	1,921				Allocated from Dynamic		
Pendulum LLC	Risk Assessment	3,500				745		
Joint Commission Resources	Accreditation	1,200						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				Entertainment Expense
(For legal fee disclosure, see page 39 of instructions)			\$ 585,554		\$	()		
						(agree to Sch. V, line 24, col. 8)		
						TOTAL		
						\$ 6,250		

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Sterling Pavilion

0040436

Report Period Beginning:

01/01/14

Ending:

12/31/14

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 - \$12,487
- (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. \$ 423 Line 10-02
- (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. \$ 219,175
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% 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.