FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0040071

Facility Name: Monroe Pavilion Health/Treatment Ctr

Address: 1400 West Monroe Street (Number) Chicago (City) 60607 (Zip Code)

County: Cook

Telephone Number: (312) 666-4090 **Fax #** (312) 421-0134

HFS ID Number:

Date of Initial License for Current Owners: 07/01/1994

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title) Kimberley A. Waite, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	136	Intermediate (ICF)	136	49,640	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	136	TOTALS	136	49,640	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	45,389	31	3,136	48,556	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,389	31	3,136	48,556	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.82%

D. How many bed-hold days during this year were paid by the Department?
445 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 7/1/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	209,710	15,487	8,106	233,303		233,303		233,303			1
2	Food Purchase		184,020		184,020	(9,636)	174,384	(1)	174,383			2
3	Housekeeping	128,545	32,839	368	161,752		161,752		161,752			3
4	Laundry		7,186		7,186		7,186		7,186			4
5	Heat and Other Utilities			126,492	126,492		126,492	1,548	128,040			5
6	Maintenance	42,602	15,765	75,391	133,758		133,758	22,076	155,834			6
7	Other (specify):*											7
8	**TOTAL General Services**	380,857	255,297	210,357	846,511	(9,636)	836,875	23,623	860,498			8
	B. Health Care and Programs											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	1,503,122	108,489	5,485	1,617,096		1,617,096	(4,022)	1,613,074			10
10a	Therapy											10a
11	Activities	90,512	6,398	371	97,281		97,281		97,281			11
12	Social Services	20,912		2,594	23,506		23,506		23,506			12
13	CNA Training											13
14	Program Transportation			149	149		149		149			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,614,546	114,887	35,599	1,765,032		1,765,032	(4,022)	1,761,010			16
	C. General Administration											
17	Administrative	97,296		266,451	363,747		363,747	(253,458)	110,289			17
18	Directors Fees											18
19	Professional Services			112,530	112,530	(4,664)	107,866	(18,809)	89,056			19
20	Dues, Fees, Subscriptions & Promotions			46,410	46,410		46,410	(40,020)	6,390			20
21	Clerical & General Office Expenses	39,870	15,026	69,070	123,966		123,966	74,877	198,843			21
22	Employee Benefits & Payroll Taxes			347,996	347,996	9,636	357,632		357,632			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,659	2,659		2,659	788	3,447			24
25	Other Admin. Staff Transportation			99	99		99	746	845			25
26	Insurance-Prop.Liab.Malpractice			160,939	160,939		160,939	6,507	167,446			26
27	Other (specify):*							25,877	25,877			27
28	**TOTAL General Administration**	137,166	15,026	1,006,154	1,158,346	4,972	1,163,318	(203,492)	959,825			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,132,569	385,210	1,252,110	3,769,889	(4,664)	3,765,225	(183,892)	3,581,333			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr #0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			46,391	46,391		46,391	14,839	61,230			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,960	15,960		15,960	314,163	330,123			32
33	Real Estate Taxes					4,664	4,664	172,348	177,013			33
34	Rent-Facility & Grounds			1,180,098	1,180,098		1,180,098	(1,179,905)	193			34
35	Rent-Equipment & Vehicles			8,085	8,085		8,085	2,628	10,713			35
36	Other (specify):*							30,685	30,685			36
37	**TOTAL Ownership**			1,250,534	1,250,534	4,664	1,255,198	(645,242)	609,957			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			74,460	74,460		74,460		74,460			42
43	Other (specify):*			55,350	55,350		55,350	(55,350)				43
44	**TOTAL Special Cost Centers**			129,810	129,810		129,810	(55,350)	74,460			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,132,569	385,210	2,632,454	5,150,233		5,150,233	(884,484)	4,265,749			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,004)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(110,306)	30		9
10	Interest and Other Investment Income	(2,230)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	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	(8,583)	21		18
19	Entertainment	(94)	25		19
20	Contributions	(25,300)	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	(14,000)	21		24
25	Fund Raising, Advertising and Promotional	(7,132)	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	(127,328)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (295,978)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(588,505)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (588,505)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (884,484)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Monroe Pavilion Health/Treatment Ctr

ID# 0040071

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Copy Income	$ (273)	21	1
2	Jury Duty	(34)	21	2
3	Phone Income	(45)	21	3
4	Veterans Expense	(11,740)	10	4
5	Patient Needs	(9,852)	10	5
6	Patient Clothing	(125)	10	6
7	Bank Charges	(12,170)	21	7
8	Annual Report	(325)	20	8
9	Alliance for Living- PAC Dues	(8,087)	20	9
10	Non-Allowable Legal Fees	(24,836)	19	10
11	Non-Allowable Administrative Fee	(55,350)	43	11
12	Additional R & M	19,309	06	12
13	Misc Income	(203)	21	13
14	Building Co:			14
15	Legal Fees	(350)	19	15
16	Accounting & Auditing Fees	(10,650)	19	16
17	Bank Fees	(1,740)	21	17
18	Amortization	(3,886)	36	18
19	Licenses and Fees	(3,970)	20	19
20	Misc. Admin	(3,000)	21	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**	(127,328)		49

Monroe Pavilion Health/Treatment Ctr

ID# 0040071

Report Period Beginning: 01/01/10

Ending: 12/31/10

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

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr **#** 0040071 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(1)											(1)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,548									1,548	5
6	Maintenance	18,305		3,771									22,076	6
7	Other (specify):*													7
8	**TOTAL General Services**	18,304		5,319									23,623	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(21,717)				17,695							(4,022)	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**	(21,717)				17,695							(4,022)	16
	C. General Administration													
17	Administrative			(236,424)	3,239	(20,273)							(253,458)	17
18	Directors Fees													18
19	Professional Services	(35,836)	11,000	6,007		20							(18,809)	19
20	Fees, Subscriptions & Promotions	(44,814)	3,970	804		20							(40,020)	20
21	Clerical & General Office Expenses	(40,049)	4,740	95,635		14,550							74,877	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			688		100							788	24
25	Other Admin. Staff Transportation	(94)		701		139							746	25
26	Insurance-Prop.Liab.Malpractice		5,521	986									6,507	26
27	Other (specify):*			21,274	131	4,472							25,877	27
28	**TOTAL General Administration**	(120,793)	25,231	(110,329)	3,370	(972)							(203,492)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(124,206)	25,231	(105,010)	3,370	16,723							(183,892)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Monroe Pavilion Health/Treatment Ctr** **#** **0040071** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(110,306)	120,323	4,735		86							14,839	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,230)	314,097	2,175		121							314,163	32
33	Real Estate Taxes		168,107	4,241									172,348	33
34	Rent-Facility & Grounds		(1,180,098)	193									(1,179,905)	34
35	Rent-Equipment & Vehicles			2,628									2,628	35
36	Other (specify):*	(3,886)	34,571										30,685	36
37	**TOTAL Ownership**	(116,422)	(543,000)	13,973		207							(645,242)	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):*	(55,350)											(55,350)	43
44	**TOTAL Special Cost Centers**	(55,350)											(55,350)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(295,978)	(517,769)	(91,036)	3,370	16,930							(884,484)	45

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 1,180,098	Monroe Pavilion Associates	100.00%	$	$ (1,180,098)	1
2	V	32	Interest Income	132	Monroe Pavilion Associates	100.00%	314,229	314,097	2
3	V	19	Legal Expense		Monroe Pavilion Associates	100.00%	350	350	3
4	V	19	Accounting & Audit Fees		Monroe Pavilion Associates	100.00%	10,650	10,650	4
5	V	21	Bank Fees		Monroe Pavilion Associates	100.00%	1,740	1,740	5
6	V	21	Misc. Admin		Monroe Pavilion Associates	100.00%	3,000	3,000	6
7	V	30	Depreciation		Monroe Pavilion Associates	100.00%	120,323	120,323	7
8	V	36	Amortization		Monroe Pavilion Associates	100.00%	3,886	3,886	8
9	V	33	Real Estate Taxes		Monroe Pavilion Associates	100.00%	168,107	168,107	9
10	V	26	Property & Liability Insurance		Monroe Pavilion Associates	100.00%	5,521	5,521	10
11	V	20	License and Fees		Monroe Pavilion Associates	100.00%	3,970	3,970	11
12	V	36	MIP Insurance		Monroe Pavilion Associates	100.00%	30,685	30,685	12
13	V								13
14	Total			$ 1,180,230			$ 662,461	$ * (517,769)	14

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 1,548	$ 1,548	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	3,771	3,771	16
17	V	17	ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	9,754	9,754	17
18	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	6,007	6,007	18
19	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	804	804	19
20	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	95,635	95,635	20
21	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	688	688	21
22	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	701	701	22
23	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	986	986	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	21,274	21,274	24
25	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	4,735	4,735	25
26	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,175	2,175	26
27	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	4,241	4,241	27
28	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	193	193	28
29	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	2,628	2,628	29
30	V								30
31	V	17	MANAGEMENT FEES	246,178				(246,178)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 246,178			$ 155,142	$ * (91,036)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	3,239	$ 3,239	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	131	131	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			$			$ 3,370	$ * 3,370	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	CLINICAL SALARIES	$	CLINICAL CONSULTING SERVICES, LLC	100.00%	$ 17,695	$ 17,695	15
16	V	19	PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%	20	20	16
17	V	20	DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	20	20	17
18	V	21	OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	12,927	12,927	18
19	V	21	OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	1,623	1,623	19
20	V	24	CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	100	100	20
21	V	25	AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	139	139	21
22	V	27	PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	2,106	2,106	22
23	V	27	OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	2,366	2,366	23
24	V	30	DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	86	86	24
25	V	32	INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	121	121	25
26	V								26
27	V	17	MANAGEMENT FEES	20,273				(20,273)	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			$ 20,273			$ 37,203	$ * 16,930	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Workers Compensation	$ 15,000	Diamond Insurance	100.00%	$ 15,000	$	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			$ 15,000			$ 15,000	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Hartman	Relative	Administrative	0%	See Attached	0.48	1.20%		$		1
2	Robert Hartman	Owner	Administrative	55.75	See Attached	0.81	1.62%	Alloc. Salary	3,239	17-7	2
3											3
4											4
5											5
6											6
7											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 amounts anticipated to be considered allowable										11
12	by the Illinois Department of HFS.										12
13								TOTAL	$ 3,239		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 Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 7257 N. LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,226,110	16	$ 38,227	$	49,640	$ 1,548	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,226,110	16	93,156		49,640	3,771	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,226,110	16	240,928	240,928	49,640	9,754	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,226,110	16	148,362		49,640	6,007	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,226,110	16	19,864		49,640	804	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,226,110	16	2,362,190	2,024,369	49,640	95,635	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,226,110	16	16,998		49,640	688	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,226,110	16	17,306		49,640	701	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,226,110	16	24,362		49,640	986	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,226,110	16	525,475		49,640	21,274	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,226,110	16	116,967		49,640	4,735	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	53,729		49,640	2,175	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,226,110	16	104,761		49,640	4,241	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,226,110	16	4,765		49,640	193	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,226,110	16	64,914		49,640	2,628	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,832,004	$ 2,265,297		$ 155,142	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 7257 N. LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	20	16	80,000	80,000	1	3,239	1
2										2
3										3
4										4
5										5
6	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	20	16	3,234		1	131	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					$ 83,234	$ 80,000		$ 3,370	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: CLINICAL CONSULTING SERVICES, LLC
Street Address: 7257 N. LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,226,110	16	$ 437,066	$ 437,066	49,640	17,695	1
2	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,226,110	16	484		49,640	20	2
3	20	DUES, LICENSE & INSPECTION	AVAIL. CENSUS DAYS	1,226,110	16	488		49,640	20	3
4	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,226,110	16	319,300	319,300	49,640	12,927	4
5	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	40,077		49,640	1,623	5
6	24	CONTINUING EDUCATION / SE	AVAIL. CENSUS DAYS	1,226,110	16	2,480		49,640	100	6
7	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	3,430		49,640	139	7
8	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,226,110	16	52,028		49,640	2,106	8
9	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,226,110	16	58,440		49,640	2,366	9
10	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,226,110	16	2,132		49,640	86	10
11	32	INTEREST	AVAIL. CENSUS DAYS	1,226,110	16	2,985		49,640	121	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					$ 918,910	$ 756,366		$ 37,203	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Diamond Insurance
Street Address: 40 Slokie Blvd., Suite 105
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 599-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Workers Compensation	Direct Allocation			$	$		$ 15,000	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					$	$		$ 15,000	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD Loan		X	Mortgage			$	$ 6,095,532			$ 314,229	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Boulevard		X	Line of Credit	Interest Only			500,000	Prime+1		15,960	6
7	Allocated from NuCare										2,175	7
8	See Supplemental Schedule										121	8
9	TOTAL Facility Related						$	$ 6,595,532			$ 332,486	9
	B. Non-Facility Related*											
10	Interest Income (Bldg Co.)		X								(132)	10
11	Interest Income		X								(2,230)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (2,362)	14
15	TOTALS (line 9+line14)						$	$ 6,595,532			$ 330,123	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 30,685 **Line #** 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from Clinical Conlts.		X				$	$			$ 121	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										121	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 2009 report.	$ 175,307	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.)	$ 171,760	2
3. Under or (over) accrual (line 2 minus line 1).	$ (3,547)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 175,895	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.	$ 4,664	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** $ 193 **For** 2000 **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.	$ 177,012	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	125,328	8
2006	167,084	9
2007	165,300	10
2008	166,959	11
2009	167,519	12

2009 Accrual=$167,519 X 1.03 = $172,685 (Rounded)
Allocated From NuCare $4,241

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Monroe Pavilion Health/Treatment Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040071

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-17-102-043-0000	Long Term Care Property	$ 167,518.73	$ 167,518.73
2.	10-27-319-028-0000	Allocated- NuCare Services	$ 81,288.74	$ 3,126.36
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 248,807.47	$ 170,645.09

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

IMPORTANT NOTICE

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

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

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

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

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Monroe Pavilion Health/Treatment Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040071

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,004 B. General Construction Type: Exterior Brick Frame Reinforced Concrete Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	39,159	1982	$ 30,464	1
2	Allocated from 7257 N Lincoln Ave		2004	6,154	2
3	TOTALS	39,159		$ 36,618	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	13,951		20	358	358	5,829	9
10	Various			1995	13,124		20	656	656	10,280	10
11	Various			1996	19,194		20	960	960	13,620	11
12	Various			1997	32,365		20	1,618	1,618	21,878	12
13	Various			1998	50,879		20	2,544	2,544	31,426	13
14	Various			1999	63,549		20	3,177	3,177	37,039	14
15	Various			2000	62,515		20	3,126	3,126	33,496	15
16	Various			2001	42,063		20	2,103	2,103	20,200	16
17	Various			2002	32,776		20	1,872	1,872	15,929	17
18	Various			2003	195,702		20	13,138	13,138	182,527	18
19	Various			2004	5,054		20	372	372	2,522	19
20	Various			2005	4,804		20	445	445	2,331	20
21	Various			2006	143,838		20	9,048	9,048	43,437	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

*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 Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		2,097,724			1,929	1,929	2,071,989	67
68	Related Party Allocations (Pages 12H & 12I)		117,159	3,668		4,696	1,028	19,829	68
69	Financial Statement Depreciation			166,714			(166,714)		69
70	TOTAL (lines 4 thru 69)		$ 2,894,697	$ 170,382		$ 46,042	$ (124,339)	$ 2,512,332	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,894,697	$ 170,382		$ 46,042	$ (124,339)	$ 2,512,332	1
2	Digital Video Multiplexer Recorded Triplex	2008	2,139		20	428	428	1,283	2
3	New Relief Valve; Copper Tubings And Fittings; Freon	2008	2,356		20	337	337	842	3
4	Installation Of Von Duprin 88 Mortise Exit Device Key And Missi	2008	1,932		20	193	193	419	4
5	Concrete Drain	2009	4,500		20	450	450	825	5
6	Concrete Wall	2009	3,532		20	236	236	353	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 2,909,156	$ 170,382		$ 47,686	$ (122,696)	$ 2,516,054	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,909,156	$ 170,382		$ 47,686	$ (122,696)	$ 2,516,054	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,909,156	$ 170,382		$ 47,686	$ (122,696)	$ 2,516,054	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 2,909,156	$ 170,382		$ 47,686	$ (122,696)	$ 2,516,054	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)		$ 2,909,156	$ 170,382		$ 47,686	$ (122,696)	$ 2,516,054	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,909,156	$ 170,382		$ 47,686	$ (122,696)	$ 2,516,054	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)		$ 2,909,156	$ 170,382		$ 47,686	$ (122,696)	$ 2,516,054	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3		1978	2,059,134		26			2,059,134	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2004	5,493		20	275	275	3,105	9
10	Various	2005	11,502		20	574	574	6,339	10
11	2 Dome DDC Camera / Install Monitors	2007	1,871		20	94	94	453	11
12	Drapery Panel; Curtains	2008	19,724		20	986	986	2,958	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 2,097,724	$		$ 1,929	$ 1,929	$ 2,071,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Avenue	2004	52,470	1,345	35	1,499	154	10,681	3
4	Allocated from Clinical Consulting Services	2004	2,915	75	35	83	8	593	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 7257 N. Lincoln Avenue	2005	4,783	208	20	309	101	1,639	9
10	Allocated from 7257 N. Lincoln Avenue	2004	1,043		20	52	52	339	10
11									11
12	Allocated from Clinical Consulting Services	2005	266	12	20	17	5	91	12
13	Allocated from Clinical Consulting Services	2004	58		20	3	3	19	13
14									14
15	Allocated from NuCare Services	2003	474	17	20	24	7	169	15
16	Allocated from NuCare Services	2004	9,628	351	20	482	131	3,234	16
17	Allocated from NuCare Services	2005	571	21	20	29	8	167	17
18	Allocated from NuCare Services	2006	774	28	20	39	11	169	18
19	Allocated from NuCare Services	2008	816	30	20	41	11	92	19
20	Allocated from NuCare Services	2009	41,343	1,507	20	2,067	560	2,585	20
21	Allocated from NuCare Services	2010	2,018	74	20	51	(23)	51	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 117,159	$ 3,668		$ 4,696	$ 1,028	$ 19,829	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 266,308	$ 951	$ 10,319	$ 9,368	10	$ 173,314	71
72	Current Year Purchases	20,904	190	3,024	2,834	10	3,024	72
73	Fully Depreciated Assets	153,361		173	173	10	153,361	73
74								74
75	TOTALS	$ 440,573	$ 1,141	$ 13,516	$ 12,375		$ 329,699	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1991 FORD E150	1994	$ 2,200	$	$	$	5	$	76
77		Allocated from Nucare Service Cc	2010	359	15	30	15	5	30	77
78										78
79										79
80	TOTALS			$ 2,559	$ 15	$ 30	$ 15		$ 30	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)	$	3,388,906	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	171,538	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	61,232	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(110,306)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,845,783	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction In Progress	$ 221,325	92
93	Building Company CIP	35,602	93
94			94
95		$ 256,927	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 Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Alloc. From NuCare (Parking Lot Rental)				193			6
7	TOTAL				$ 193 **			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.	/2011	$
13.	/2012	$
14.	/2013	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 10,713 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 192,184	1
2	Cash-Patient Deposits	1	1	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	795,385	817,982	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,455	90,193	6
7	Other Prepaid Expenses	94,106	94,106	7
8	Accounts Receivable (owners or related parties)	720,618	720,618	8
9	Other(specify): See Attached Schedule	2,261	225,077	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,674,826	$ 2,140,161	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		437,264	13
14	Buildings, at Historical Cost		2,116,772	14
15	Leasehold Improvements, at Historical Cost	691,197	3,081,427	15
16	Equipment, at Historical Cost	395,452	649,786	16
17	Accumulated Depreciation (book methods)	(863,531)	(3,474,065)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	223,551	370,883	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 446,669	$ 3,182,067	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,121,495	$ 5,322,228	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 341,390	$ 341,620	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1	1	28
29	Short-Term Notes Payable	500,000	500,000	29
30	Accrued Salaries Payable	202,404	202,404	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,114	8,114	31
32	Accrued Real Estate Taxes(Sch.IX-B)		175,895	32
33	Accrued Interest Payable		26,008	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,465	8,465	35
	Other Current Liabilities(specify):			
36	See Attached Schedule		15,059	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,060,374	$ 1,277,566	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,095,532	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,095,532	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,060,374	$ 7,373,098	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,061,121	$ (2,050,870)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,121,495	$ 5,322,228	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 860,647	1
2	Restatements (describe):		2
3	**Distributions**	300,000	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,160,647	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(99,526)	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)**	$ (99,526)	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)**	$ 1,061,121	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,050,568	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,050,568	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	(2,839)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (2,839)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,230	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,230	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	748	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 748	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,050,707	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	846,511	31
32	Health Care	1,765,032	32
33	General Administration	1,158,346	33
	B. Capital Expense		
34	Ownership	1,250,534	34
	C. Ancillary Expense		
35	Special Cost Centers	55,350	35
36	Provider Participation Fee	74,460	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,150,233	40
41	**Income before Income Taxes (line 30 minus line 40)****	(99,526)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (99,526)	43

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

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

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

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

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,821	2,086	$ 87,731	$ 42.06	1
2	Assistant Director of Nursing	2,274	2,461	70,025	28.45	2
3	Registered Nurses	2,088	4,526	123,995	27.40	3
4	Licensed Practical Nurses	51,151	22,866	493,682	21.59	4
5	CNAs & Orderlies	41,820	47,013	538,812	11.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,953	2,086	31,138	14.93	9
10	Activity Assistants	6,360	6,079	59,374	9.77	10
11	Social Service Workers	790	833	20,912	25.10	11
12	Dietician	1,885	2,086	48,948	23.47	12
13	Food Service Supervisor					13
14	Head Cook	426	4,817	46,820	9.72	14
15	Cook Helpers/Assistants	9,553	10,559	113,942	10.79	15
16	Dishwashers					16
17	Maintenance Workers	2,675	2,863	42,602	14.88	17
18	Housekeepers	10,383	11,601	128,545	11.08	18
19	Laundry					19
20	Administrator	1,922	2,086	96,755	46.38	20
21	Assistant Administrator					21
22	Other Administrative	15	15	541	36.07	22
23	Office Manager					23
24	Clerical	2,019	2,182	39,870	18.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	8,305	9,408	151,712	16.13	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,840	1,989	37,165	18.69	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	147,280	135,556	$ 2,132,569 *	$ 15.73	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	160	$ 8,106	01-03	35
36	Medical Director	Monthly	27,000	09-03	36
37	Medical Records Consultant	Monthly	1,982	10-03	37
38	Nurse Consultant	1	275	10-03	38
39	Pharmacist Consultant	Monthly	3,228	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	7	371	11-03	44
45	Social Service Consultant	46	2,594	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	213	$ 43,556		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wayne Hanik	Administrator	0.00%	$ 96,755
Kathleen Brander	Dir. Regulatory Mgmt.	0.00%	541
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,296

B. Administrative - Other

Description	Amount
NuCare Services Corp - Administrative Fees	$ 246,178
Clinical Consulting-Administrative Fees	20,273
TOTAL (agree to Schedule V, line 17, col. 3)	$ 266,451
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg, &Rothblatt	Accounting	$ 26,195
Emdeon Business Service	Computer Services	133
Giftrap	Computer Services	3,770
HDSI	Computer Services	6,688
MDI Achieve	Computer Services	5,076
Personnel Planners	Unemployment Consulting	965
See Attached	Legal	62,619
Michigan Peer Review Org.	Healthcare Consulting	3,015
MTS Consulting	Tax Consulting	244
Robert Coleman	Healthcare Consulting	325
Avenue Web Media	Website Design	3,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 112,530

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 15,000
Unemployment Compensation Insurance	17,833
FICA Taxes	161,161
Employee Health Insurance	130,430
Employee Meals	9,636
Illinois Municipal Retirement Fund (IMRF)*	
City of Chicago Taxes	3,592
Pension Benefits	17,282
401(K) Matching Expense	2,489
Other Employee Benefits	209
TOTAL (agree to Schedule V, line 22, col.8)	$ 357,631

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	552
Health Care Worker Background Check	
(Indicate # of checks performed 158)	1,535
Patient Background Checks	
Subscriptions & Dues	462
Licenses & Inspections	3,017
Advertising & Promotion	7,132
Allocated from NuCare	804
Allocated from Clinical Conlts. Servcs.	20
Less: Public Relations Expense	( )
Non-allowable advertising	(7,132)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,390

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,659
Allocated from NuCare	688
Allocated from Clinical Conlts. Servcs.	100
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,447

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health/Treatment Ctr # 0040071 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Assoc. of HC $1,722; Alli. for Living $8,160**

(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. $ **174** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO ____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **74,460**
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? **N/A**

(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? ____ 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. $ **9,636** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln14**
d. Have vehicle usage logs been maintained? **N/A**
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? ____
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.