FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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.

I. IDPH License ID Number: 0040071

Facility Name: Monroe Pav Hlth Treatmnt Ctr

Address: 1400 West Monroe St (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: 7/1/1994

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 01/01/14 to 12/31/14 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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1 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	39,527	6	3,531	43,064	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,527	6	3,531	43,064	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.75%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 07/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 07/01/1994 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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	209,261	18,622	6,768	234,651		234,651		234,651			1
2	Food Purchase		205,602		205,602	(12,045)	193,557		193,557			2
3	Housekeeping			118,199	118,199		118,199		118,199			3
4	Laundry		1,133	79,238	80,371		80,371		80,371			4
5	Heat and Other Utilities			171,235	171,235		171,235	608	171,843			5
6	Maintenance	34,310	24,796	74,654	133,760		133,760	7,573	141,333			6
7	Other (specify):*							256	256			7
8	TOTAL General Services	243,571	250,153	450,094	943,818	(12,045)	931,773	8,437	940,210			8
	B. Health Care and Programs											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	1,327,459	110,563	8,719	1,446,741		1,446,741	(56,084)	1,390,657			10
10a	Therapy											10a
11	Activities	96,133	10,501	1,440	108,074		108,074		108,074			11
12	Social Services	162,598		728	163,326		163,326		163,326			12
13	CNA Training											13
14	Program Transportation			4,620	4,620		4,620		4,620			14
15	Other (specify):*							1,069	1,069			15
16	TOTAL Health Care and Programs	1,586,190	121,064	42,507	1,749,761		1,749,761	(55,015)	1,694,746			16
	C. General Administration											
17	Administrative	76,308		188,944	265,252		265,252	(171,415)	93,837			17
18	Directors Fees											18
19	Professional Services			101,639	101,639	(11,870)	89,769	730	90,499			19
20	Dues, Fees, Subscriptions & Promotions			37,820	37,820		37,820	(25,527)	12,293			20
21	Clerical & General Office Expenses	85,729	16,167	129,742	231,638		231,638	48,816	280,454			21
22	Employee Benefits & Payroll Taxes			372,013	372,013	12,045	384,058		384,058			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,495	6,495		6,495	65	6,560			24
25	Other Admin. Staff Transportation							3,569	3,569			25
26	Insurance-Prop.Liab.Malpractice			248,938	248,938		248,938	8,653	257,591			26
27	Other (specify):*							12,556	12,556			27
28	TOTAL General Administration	162,037	16,167	1,085,591	1,263,795	175	1,263,970	(122,553)	1,141,418			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,991,798	387,384	1,578,192	3,957,374	(11,870)	3,945,504	(169,131)	3,776,374			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr #0040071 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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			35,458	35,458		35,458	36,208	71,666			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,333	34,333		34,333	294,864	329,197			32
33	Real Estate Taxes					11,870	11,870	168,789	180,659			33
34	Rent-Facility & Grounds			699,215	699,215		699,215	(698,654)	561			34
35	Rent-Equipment & Vehicles			11,681	11,681		11,681	1,672	13,353			35
36	Other (specify):*							28,588	28,588			36
37	**TOTAL Ownership**			780,687	780,687	11,870	792,557	(168,533)	624,024			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**											44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,991,798	387,384	2,358,879	4,738,061		4,738,061	(337,664)	4,400,397			45

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,178)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(103,486)	30		9
10	Interest and Other Investment Income	(90)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(9,750)	21		18
19	Entertainment	(723)	24		19
20	Contributions	(14,249)	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	(47,629)	21		24
25	Fund Raising, Advertising and Promotional	(4,439)	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	(131,314)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (312,858)		$	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)	(24,805)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (24,805)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (337,664)		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

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Monroe Pav Hlth Treatmnt Ctr

ID# **0040071**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (6,087)	21	1
2	Jury Duty Income	(17)	10	2
3	Patient Needs	(5,799)	10	3
4	Patient Clothing	(967)	10	4
5	Veterans Expense	(61,195)	10	5
6	Bank Charges	(15,785)	21	6
7	Office - Outside Labor	(4,962)	21	7
8	Building Co: Licenses and Fees	(100)	20	8
9	Building Co: Professional Fees	(10,800)	19	9
10	Building Co: IL Replacement Tax	(1,760)	21	10
11	Building Co: Amortization of Loan Fees	(3,886)	36	11
12	Record Copies	(15)	21	12
13	Prior Period Adjustment	(205)	21	13
14	Annual Report	(175)	20	14
15	Non-Allowable Legal Fees	(4,689)	19	15
16	Alliance for Living- PAC Dues	(7,585)	20	16
17	Web Media	(195)	21	17
18	Capitalized R&M	(4,343)	06	18
19	Additional R&M	3,476	06	19
20	Non-Allowable Fees	(6,224)	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**	(131,314)		49

Monroe Pav Hlth Treatmnt Ctr

ID# 0040071

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 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													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(1,178)		1,786									608	5
6	Maintenance	(867)		8,440									7,573	6
7	Other (specify):*			256									256	7
8	**TOTAL General Services**	(2,045)		10,482									8,437	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(67,978)		12,071	(24)		(153)						(56,084)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,069									1,069	15
16	**TOTAL Health Care and Programs**	(67,978)		13,140	(24)		(153)						(55,015)	16
	C. General Administration													
17	Administrative			(171,415)									(171,415)	17
18	Directors Fees													18
19	Professional Services	(15,489)	10,800	5,419									730	19
20	Fees, Subscriptions & Promotions	(26,548)	100	921									(25,527)	20
21	Clerical & General Office Expenses	(92,612)	1,760	139,669									48,816	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(723)		788									65	24
25	Other Admin. Staff Transportation			3,569									3,569	25
26	Insurance-Prop.Liab.Malpractice		8,246	407									8,653	26
27	Other (specify):*			12,556									12,556	27
28	**TOTAL General Administration**	(135,373)	20,906	(8,086)									(122,553)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(205,396)	20,906	15,536	(24)		(153)						(169,131)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense 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	(103,486)	133,677	6,017									36,208	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(90)	293,499	1,455									294,864	32
33	Real Estate Taxes		166,392	2,397									168,789	33
34	Rent-Facility & Grounds		(698,926)	272									(698,654)	34
35	Rent-Equipment & Vehicles			1,672									1,672	35
36	Other (specify):*	(3,886)	32,474										28,588	36
37	**TOTAL Ownership**	(107,462)	(72,884)	11,814									(168,533)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(312,858)	(51,978)	27,350	(24)		(153)						(337,664)	45

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 698,926	Monroe Pavilion Associates	100.00%	$	$ (698,926)	1
2	V	32	Interest	173	Monroe Pavilion Associates	100.00%	293,672	293,499	2
3	V	21	Bank Charges		Monroe Pavilion Associates	100.00%			3
4	V	26	General & Professional Liability		Monroe Pavilion Associates	100.00%	8,246	8,246	4
5	V	20	License & Inspection		Monroe Pavilion Associates	100.00%	100	100	5
6	V	19	Professional Fees		Monroe Pavilion Associates	100.00%	10,800	10,800	6
7	V	21	IL Replacement Tax		Monroe Pavilion Associates	100.00%	1,760	1,760	7
8	V	33	Real Estate Taxes		Monroe Pavilion Associates	100.00%	166,392	166,392	8
9	V	30	Depreciation		Monroe Pavilion Associates	100.00%	133,677	133,677	9
10	V	36	Amortization		Monroe Pavilion Associates	100.00%	3,886	3,886	10
11	V	36	MIP Insurance		Monroe Pavilion Associates	100.00%	28,588	28,588	11
12	V								12
13	V								13
14	Total			$ 699,099			$ 647,121	$ * (51,978)	14

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 1,786	$ 1,786	15
16	V	6	MAINTENANCE SALARIES		NUCARE SERVICES CORP.	100.00%	2,895	2,895	16
17	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	5,545	5,545	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		NUCARE SERVICES CORP.	100.00%	256	256	18
19	V	10	CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	12,071	12,071	19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		NUCARE SERVICES CORP.	100.00%	1,069	1,069	20
21	V	17	ADMINISTRATIVE SALARIES - NON-OWNER		NUCARE SERVICES CORP.	100.00%	17,529	17,529	21
22	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	5,419	5,419	22
23	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	921	921	23
24	V	21	CLERICAL & GENERAL SALARIES		NUCARE SERVICES CORP.	100.00%	117,650	117,650	24
25	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	22,018	22,018	25
26	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	788	788	26
27	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	3,569	3,569	27
28	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	407	407	28
29	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		NUCARE SERVICES CORP.	100.00%	12,556	12,556	29
30	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	6,017	6,017	30
31	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	1,455	1,455	31
32	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	2,397	2,397	32
33	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	272	272	33
34	V	35	AUTO LEASE		NUCARE SERVICES CORP.	100.00%	1,672	1,672	34
35	V								35
36	V	17	BOOKKEEPING FEES	188,944	NUCARE SERVICES CORP.	100.00%		(188,944)	36
37	V								37
38	V								38
39	Total			$ 188,944			$ 216,294	$ * 27,350	39

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	DME and Medical Supplies	$ 258	Integra Healthcare Equipment		$ 234	$ (24)	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			$ 258			$ 234	$ * (24)	39

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	22	Workers Compensation	$ 49,080	MAPLE LEAF		$ 49,080	$	15
16	V	26	Liability Insurance	243,940	MAPLE LEAF		243,940		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			$ 293,020			$ 293,020	$ *	39

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Ambulance	$ 660	Lifeline Ambulance	100.00%	$ 507	$ (153)	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			$ 660			$ 507	$ * (153)	39

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BARRY AND RANDY CARR	4.750%	CALIFORNIA GARDENS CORP.	CHICAGO	MONROE PAVILION ASSOCIAT	CHICAGO	BUILDING CO.	1
2	FEIGE KNOBEL DISCRETIONARY TRUST	1.584%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REH	CHICAGO	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY INS	2
3	GARY HOKIN	14.589%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	GERRY JENICH	5.000%	CLARIDGE IMPERIAL, LTD.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	4
5	MARK HOLLANDER DISCRETIONARY TRUST	1.583%	JACKSON CORP.	CHICAGO	NUCARE SERVICES	LINCOLNWOOD	BOOKKEEPING	5
6	RAJCHENBACH FAMILY TRUST	4.750%	RENAISSANCE EAST	MESA, ARIZONA	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	6
7	ROBERT HARTMAN	55.750%	RENAISSANCE VILLAGE AL	MESA, ARIZONA	DRAKE LOUIS ENTERPRISE	LINCOLNWOOD	MANAGEMENT CO.	7
8	SHARON HOLLANDER DISCRETIONARY TRUST	1.583%	RENAISSANCE VILLAGE IL	MESA, ARIZONA	INTEGRA HEALTHCARE EQUI	ELMHURST	DME & MEDICAL SUPPLIES	8
9	DAVID HOKIN	10.411%	RENAISSANCE WEST	MESA, ARIZONA	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	9
10			RENAISSANCE PARK SOUTH	CHICAGO				10
11			THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO				11
12			ARIA POST ACUTE CARE	HILLSIDE				12
13			THE RENAISSANCE AT MIDWAY, INC.	CHICAGO				13
14			THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO				14
15			CLAREMONT HANOVER PARK	HANOVER PARK				15
16			SEVEN OAKS	GLENDALE, WISC.				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1	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	N/A								$		1
2											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 the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		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 Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	1,239,904	17	$ 44,608	$	49,640	$ 1,786	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	72,310	72,310	49,640	2,895	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,239,904	17	138,492		49,640	5,545	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,239,904	17	6,405		49,640	256	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	301,506	301,506	49,640	12,071	5
6	15	EMPLOYEE BENEFITS - CLIN	AVAIL. CENSUS DAYS	1,239,904	17	26,708		49,640	1,069	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	437,828	437,828	49,640	17,529	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,239,904	17	135,365		49,640	5,419	8
9	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,239,904	17	23,010		49,640	921	9
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,239,904	17	2,938,655	2,938,655	49,640	117,650	10
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,239,904	17	549,976		49,640	22,018	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,239,904	17	19,695		49,640	788	12
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,239,904	17	89,139		49,640	3,569	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	1,239,904	17	10,164		49,640	407	14
15	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,239,904	17	313,624		49,640	12,556	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,239,904	17	150,292		49,640	6,017	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,239,904	17	36,349		49,640	1,455	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,239,904	17	59,877		49,640	2,397	18
19	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,239,904	17	6,796		49,640	272	19
20	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,239,904	17	41,766		49,640	1,672	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,402,565	$ 3,750,299		$ 216,294	25

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Integra Healthcare Equipment, LLC
Street Address: 747 Church Road
City / State / Zip Code: Elmhurst, IL 60126
Phone Number: (630) 834-3700
Fax Number: (630) 834-1500

	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	DME & Medical Supplies	Direct Cost			$	$		$ 234	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					$	$		$ 234	25

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Maple Leaf Insurance
Street Address: PO Box 69,720 West Bay Rd.
City / State / Zip Code: Grand Cayman KY1-1102
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	22	Workers Compensation	Direct Allocation			$	$		$ 49,080	1
2	26	Libility Insurance	Direct Allocation						243,940	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					$	$		$ 293,020	25

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Lifeline Ambulance LLC
Street Address: 2424 S. Wabash Avenue
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	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	AMBULANCE	DIRECT ALLOCATION			$	$		$ 507	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					$	$		$ 507	25

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD Loan		X	Mortgage			$	$ 5,684,533			$ 293,672	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit				682,663			34,334	6
7	Allocated from Nucare		X								1,455	7
8												8
9	TOTAL Facility Related						$	$ 6,367,196			$ 329,461	9
	B. Non-Facility Related*											
10	Interest Income		X								(90)	10
11	Interest Income (Bldg Co.)		X								(173)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (263)	14
15	TOTALS (line 9+line14)						$	$ 6,367,196			$ 329,198	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 28,588** **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.)**

**** 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 Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 185,315	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.)		$ 173,962	2
3. Under or (over) accrual (line 2 minus line 1).		$ (11,353)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 180,143	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.)**		$ 11,870	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** $ 28,163 **For** 2000-2003, 2008 **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.		$ 180,659	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009	167,519	8
2010	144,652	9
2011	144,050	10
2012	176,490	11
2013	171,564	12

2014 Accrual = $171,564 x 1.05 = $180,143

Allocated from Nucare: $2,397

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Monroe Pav Hlth Treatmnt 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 2013 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 2013.

	(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	$ 171,564.36	$ 171,564.36
2.	10-27-319-028-0000	Home Office Allocation	$ 89,368.57	$ 2,397.19
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 260,932.93	$ 173,961.55

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Monroe Pav Hlth Treatmnt 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 2000 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 2000.

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	4,292	2
3	TOTALS	39,159		$ 34,756	3

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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	136			1978	$ 2,116,772	$ 133,677	26	$	$ (133,677)	$ 2,116,772	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	32,967		20			32,967	9
10	Various			1987	4,735		20	820	820	4,735	10
11	Various			1988	8,738		20	1,792	1,792	8,738	11
12	Various			1989	11,001		20	2,605	2,605	11,001	12
13	Various			1990	1,919		20	515	515	1,919	13
14	Various			1991	5,128		20	1,540	1,540	5,128	14
15	Various			1992	4,600		20	1,527	1,527	4,600	15
16	Various			1993	17,616		20	8,564	8,564	17,616	16
17	Various			1994	13,951		20	358	358	7,260	17
18	Various			1995	13,124		20	656	656	12,905	18
19	Various			1996	19,194		20	960	960	17,459	19
20	Various			1997	32,365		20	1,618	1,618	28,351	20
21	Various			1998	50,879		20	2,544	2,544	41,601	21
22	Various			1999	63,549		20	3,177	3,177	49,749	22
23	Various			2000	62,515		20	3,126	3,126	45,999	23
24	Various			2001	42,063		20	2,103	2,103	28,613	24
25	Various			2002	32,776		20	1,164	1,164	21,776	25
26	Various			2003	195,702		20	320	320	193,057	26
27	Various			2004	5,054		20	166	166	3,804	27
28	Various			2005	4,804		20	445	445	4,112	28
29	Various			2006	143,838		20	9,048	9,048	79,630	29
30	Various			2009	8,032		20	686	686	3,921	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 Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		94,391			4,719	4,719	25,079	67
68	Related Party Allocations (Pages 12H & 12I)		71,754	2,903		2,778	(125)	25,181	68
69	Financial Statement Depreciation			35,458			(35,458)		69
70	TOTAL (lines 4 thru 69)		$ 3,057,467	$ 172,038		$ 51,230	$ (120,808)	$ 2,791,974	70

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,057,467	$ 172,038		$ 51,230	$ (120,808)	$ 2,791,974	1
2	Paint 16 Rooms, Door Frames, 1 Tv Room, 2 Bathrooms On 1St &	2011	4,125		20	413	413	1,478	2
3	Paint 16 Rooms, Door Frames, 1 Tv Room, 2 Bathrooms On 3Rd F	2011	3,700		20	370	370	1,326	3
4	Paint 16 Rooms, Door Frames, 1 Tv Room, 2 Bathrooms On 4Th F	2011	3,700		20	370	370	1,295	4
5	Demolish And Rebuild Shower Room, Install New Green Drywall,	2011	3,200		20	320	320	1,120	5
6	Paint Walls, Doorframes, Doors, Ceilings In Corridors On 1St, 2Nc	2011	19,420		20	1,942	1,942	6,635	6
7	Renovation 8 Common Bathrooms	2012	44,420		20	4,442	4,442	11,845	7
8	104 Pcs. Hand Rails For Stair Case	2012	3,500		20	350	350	758	8
9	Elevator Repair	2012	3,469		20	347	347	896	9
10	Boiler Repair	2012	5,920		20	592	592	1,776	10
11	Repair Elevator Door	2014	4,343		20	217	217	217	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)		$ 3,153,264	$ 172,038		$ 60,593	$ (111,445)	$ 2,819,321	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,153,264	$ 172,038		$ 60,593	$ (111,445)	$ 2,819,321	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)		$ 3,153,264	$ 172,038		$ 60,593	$ (111,445)	$ 2,819,321	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,153,264	$ 172,038		$ 60,593	$ (111,445)	$ 2,819,321	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)		$ 3,153,264	$ 172,038		$ 60,593	$ (111,445)	$ 2,819,321	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,153,264	$ 172,038		$ 60,593	$ (111,445)	$ 2,819,321	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
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19									19
20									20
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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)		$ 3,153,264	$ 172,038		$ 60,593	$ (111,445)	$ 2,819,321	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Various	2004	5,493		20	275	275	4,205	9
10	Various	2005	11,502		20	574	574	8,635	10
11	Drapery Panel; Curtains	2007	19,724		20	986	986	6,902	11
12	Fire Pump	2013	49,072		20	2,454	2,454	4,907	12
13	Stairs Work	2014	8,600		20	430	430	430	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)		$ 94,391	$		$ 4,719	$ 4,719	$ 25,079	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 94,391	$		$ 4,719	$ 4,719	$ 25,079	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
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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)		$ 94,391	$		$ 4,719	$ 4,719	$ 25,079	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Avenue		38,626	990	20	1,104	114	12,278	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from NuCare Services	2003	469	31	20	24	(7)	261	9
10	Allocated from NuCare Services	2004	9,521	623	20	477	(146)	5,105	10
11	Allocated from NuCare Services	2005	564	37	20	28	(9)	278	11
12	Allocated from NuCare Services	2006	765	50	20	38	(12)	320	12
13	Allocated from NuCare Services	2008	807	53	20	40	(13)	252	13
14	Allocated from NuCare Services	2009	12,988	850	20	649	(201)	3,643	14
15	Allocated from NuCare Services	2010	1,996	131	20	100	(31)	450	15
16	Allocated from NuCare Services	2011	108	7	20	5	(2)	21	16
17	Allocated from NuCare Services	2012	120	8	20	6	(2)	17	17
18	Allocated from NuCare Services	2014	1,501	98	20	46	(52)	46	18
19									19
20	Allocated from 7257 N. Lincoln Avenue	2005	3,521	25	20	223	198	2,107	20
21	Allocated from 7257 N. Lincoln Avenue	2004	768		20	38	38	403	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)		$ 71,754	$ 2,903		$ 2,778	$ (125)	$ 25,181	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 71,754	$ 2,903		$ 2,778	$ (125)	$ 25,181	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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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)		$ 71,754	$ 2,903		$ 2,778	$ (125)	$ 25,181	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 272,467	$ 2,702	$ 10,363	$ 7,661	10	$ 189,445	71
72	Current Year Purchases	27,197	390	595	205	10	595	72
73	Fully Depreciated Assets	188,485		45	45	10	188,484	73
74								74
75	TOTALS	$ 488,149	$ 3,092	$ 11,003	$ 7,911		$ 378,524	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1991 FORD E150	1994	$ 2,200	$	$	$	5	$	76
77		Allocated from Nucare	2014	355	23	71	48	5	313	77
78										78
79										79
80	TOTALS			$ 2,555	$ 23	$ 71	$ 48		$ 313	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)	$ 3,678,724	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 175,153	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 71,667	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (103,486)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,198,158	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		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage				289			5
6	Parking Lot				272			6
7	TOTAL				$ 561 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 11,681 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	Allocated from Nucare		$	$ 1,673	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,673	21

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

STATE OF ILLINOIS

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 33,097	$ 186,201	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,310,523	1,333,120	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,234	29,173	6
7	Other Prepaid Expenses	1,837	1,837	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		251,516	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,347,691	$ 1,801,847	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	778,559	3,230,687	15
16	Equipment, at Historical Cost	416,945	696,821	16
17	Accumulated Depreciation (book methods)	(1,023,756)	(4,121,364)	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):	102,253	198,439	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 274,001	$ 2,558,619	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,621,692	$ 4,360,466	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 260,785	$ 261,035	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,662	18,662	28
29	Short-Term Notes Payable	682,663	682,663	29
30	Accrued Salaries Payable	194,418	194,418	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,367	13,367	31
32	Accrued Real Estate Taxes(Sch.IX-B)		180,143	32
33	Accrued Interest Payable		24,254	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,465	8,465	35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,178,360	$ 1,383,007	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,684,533	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	29,722	20,471	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 29,722	$ 5,705,004	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,208,082	$ 7,088,011	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 413,610	$ (2,727,545)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,621,692	$ 4,360,466	48

*(See instructions.)

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 313,271	1	
2	Restatements (describe):		2	
3	**Workers' Comp Insurance**	5,445	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 318,716	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	94,894	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)**	$ 94,894	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)**	$ 413,610	24	*

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,742,591	1
2	Discounts and Allowances for all Levels	(12,923)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,729,668	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,020	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,020	23
	D. Non-Operating Revenue		
24	Contributions	10	24
25	Interest and Other Investment Income***	90	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 100	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	102,167	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 102,167	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,832,955	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	943,818	31
32	Health Care	1,749,761	32
33	General Administration	1,263,795	33
	B. Capital Expense		
34	Ownership	780,687	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,738,061	40
41	**Income before Income Taxes (line 30 minus line 40)****	94,894	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 94,894	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,257,239	44
45	Private Pay - Net Inpatient Revenue	720	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)	452,957	47
48	Other-(specify)	18,752	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,729,668	49

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,861	2,104	$ 78,548	$ 37.33	1
2	Assistant Director of Nursing	648	720	23,917	33.22	2
3	Registered Nurses	3,206	3,548	76,733	21.63	3
4	Licensed Practical Nurses	22,343	24,093	571,836	23.73	4
5	CNAs & Orderlies	42,899	47,779	537,511	11.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,908	2,086	32,349	15.51	9
10	Activity Assistants	5,655	6,133	63,784	10.40	10
11	Social Service Workers	8,734	9,678	162,598	16.80	11
12	Dietician	1,933	2,086	49,682	23.82	12
13	Food Service Supervisor					13
14	Head Cook	5,001	5,599	56,475	10.09	14
15	Cook Helpers/Assistants	8,496	9,482	103,104	10.87	15
16	Dishwashers					16
17	Maintenance Workers	1,995	2,236	34,310	15.34	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,021	2,086	76,308	36.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,981	4,166	85,729	20.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,842	2,095	38,914	18.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,523	123,891	$ 1,991,798 *	$ 16.08	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	144	$ 6,768	01-03	35
36	Medical Director	Monthly	27,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	3	175	10-03	38
39	Pharmacist Consultant	Monthly	8,544	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	26	1,440	11-03	44
45	Social Service Consultant	12	728	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	185	$ 44,655		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Williams	Administrator	0%	$ 76,308
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,308

B. Administrative - Other

Description	Amount
NuCare Services Corp - Bookkeeping Fees	$ 188,944
TOTAL (agree to Schedule V, line 17, col. 3)	$ 188,944
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 39,014
Frost, Ruttenberg, &Rothblatt	Accounting	19,895
McGladrey	Accounting	376
Personnel Planners	Unemployment Consulting	1,650
CDW Government	Computer Services	819
Creative Technology Solutions	Computer Services	10,599
E-Health Data Solutions	Computer Services	2,400
Formation Healthcare Group	Computer Services	1,005
HDSI Health Data System	Computer Services	5,638
Kipp Computer Solutions	Computer Services	100
Market Metrix of Delaware	Computer Services	1,726
See Supplemental Schedule		18,418
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 101,639

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,476
Unemployment Compensation Insurance	48,629
FICA Taxes	146,003
Employee Health Insurance	101,177
Employee Meals	12,045
Illinois Municipal Retirement Fund (IMRF)*	
401(K) Matching Expense	1,944
Vision Insuarnce	8
Other Employee Benefits	2,538
Pension Plan	10,240
TOTAL (agree to Schedule V, line 22, col.8)	$ 384,058

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,231
Advertising: Employee Recruitment	1,020
Health Care Worker Background Check	
(Indicate # of checks performed 77)	752
Patient Background Checks	
Dues and Subscriptions	6,431
Licenses & Inspections	939
Advertising & Promotion	4,439
Allocated from Nucare	921
Less: Public Relations Expense	( )
Non-allowable advertising	(4,439)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,293

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,773
Allocated from Nucare	788
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,561

**See instructions.

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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. **Alliance for Living $14,155**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **62** Line **10**

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

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

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $
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? **N/S** 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. $ **10,760** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **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? **No**
Firm Name: **N/A**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.