FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 Pavilion Health Ctr.

Address: 1400 West Monroe (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) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	36,456	45	2,933	39,434	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,456	45	2,933	39,434	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.44%

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 7/1/1994

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	214,390	11,881	6,868	233,139		233,139		233,139			1
2	Food Purchase		174,224		174,224	(11,081)	163,143	(2)	163,141			2
3	Housekeeping		143,823		143,823		143,823		143,823			3
4	Laundry		83,642		83,642		83,642		83,642			4
5	Heat and Other Utilities			177,275	177,275		177,275	(8,821)	168,454			5
6	Maintenance	32,359		198,966	231,325		231,325	21,071	252,396			6
7	Other (specify):*							2,366	2,366			7
8	**TOTAL General Services**	246,749	413,570	383,109	1,043,428	(11,081)	1,032,347	14,614	1,046,961			8
	B. Health Care and Programs											
9	Medical Director			25,851	25,851		25,851		25,851			9
10	Nursing and Medical Records	1,299,461	70,372	16,295	1,386,128		1,386,128	136,097	1,522,225			10
10a	Therapy											10a
11	Activities	73,337	6,522	4,326	84,185		84,185		84,185			11
12	Social Services	183,298			183,298		183,298		183,298			12
13	CNA Training											13
14	Program Transportation			616	616		616		616			14
15	Other (specify):*							31,207	31,207			15
16	**TOTAL Health Care and Programs**	1,556,096	76,894	47,088	1,680,078		1,680,078	167,304	1,847,382			16
	C. General Administration											
17	Administrative	95,118		209,519	304,637		304,637	(175,267)	129,370			17
18	Directors Fees											18
19	Professional Services			96,148	96,148	(8,971)	87,177	46,508	133,685			19
20	Dues, Fees, Subscriptions & Promotions			54,697	54,697		54,697	(18,389)	36,308			20
21	Clerical & General Office Expenses	43,469	2,404	97,375	143,248		143,248	109,407	252,655			21
22	Employee Benefits & Payroll Taxes			391,857	391,857	11,081	402,938		402,938			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,355	1,355		1,355	1,775	3,130			24
25	Other Admin. Staff Transportation			2,979	2,979		2,979	7,910	10,889			25
26	Insurance-Prop.Liab.Malpractice			205,928	205,928		205,928	5,577	211,505			26
27	Other (specify):*							38,103	38,103			27
28	**TOTAL General Administration**	138,587	2,404	1,059,858	1,200,849	2,111	1,202,960	15,624	1,218,583			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,941,432	492,868	1,490,055	3,924,355	(8,971)	3,915,384	197,542	4,112,926			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 Pavilion Health Ctr. #0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			34,267	34,267		34,267	19,307	53,574			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,464	27,464		27,464	288,001	315,465			32
33	Real Estate Taxes			13,696	13,696	8,971	22,667	149,626	172,293			33
34	Rent-Facility & Grounds			742,375	742,375		742,375	(740,845)	1,530			34
35	Rent-Equipment & Vehicles			16,753	16,753		16,753	6,646	23,399			35
36	Other (specify):*							28,107	28,107			36
37	**TOTAL Ownership**			834,555	834,555	8,971	843,526	(249,158)	594,368			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		436		436		436		436			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			3,089	3,089		3,089	(3,089)	(0)			43
44	**TOTAL Special Cost Centers**		436	3,089	3,525		3,525	(3,089)	436			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,941,432	493,304	2,327,699	4,762,435		4,762,435	(54,706)	4,707,729			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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(11,252)	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	(114,244)	30		9
10	Interest and Other Investment Income	(1,825)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2)	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	(337)	21		18
19	Entertainment				19
20	Contributions	(16,000)	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	(62,854)	21		24
25	Fund Raising, Advertising and Promotional	(1,119)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(983)	20		28
29	Other-Attach Schedule	(82,069)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (290,686)		$	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)	235,980		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 235,980		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (54,706)		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

Monroe Pavilion Health Ctr.

ID# 0040071

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Veterans Expense	$ (21,077)	10	1
2	Miscellaneous Income	(10)	21	2
3	Bank Charges	(5,976)	21	3
4	Marketing Expenses	(2,699)	43	4
5	Web Media	(390)	43	5
6	Non-Allowable Legal	(9,130)	19	6
7	Alliance for Living PAC Dues	(4,163)	20	7
8	Building Co - Accounting	(10,990)	19	8
9	Building Co - Amortization	(3,886)	36	9
10	Building Co - Data Processing	(440)	19	10
11	Building Co - Entity Expense	(20,931)	36	11
12	Building Co - IL Replacement Tax	(1,996)	21	12
13	Additional R&M	2,919	06	13
14	PAC Dues	(3,300)	20	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
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**	(82,069)		49

Monroe Pavilion Health Ctr.

ID# 0040071

Report Period Beginning: 01/01/15

Ending: 12/31/15

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Monroe Pavilion Health Ctr. **#** 0040071 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(2)											(2)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,252)		2,339	92								(8,821)	5
6	Maintenance	2,919		16,059	2,094								21,071	6
7	Other (specify):*			2,020	346								2,366	7
8	**TOTAL General Services**	(8,335)		20,418	2,532								14,614	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(21,077)		141,093	16,081								136,097	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			27,529	3,679								31,207	15
16	**TOTAL Health Care and Programs**	(21,077)		168,621	19,759								167,304	16
	C. General Administration													
17	Administrative			(177,642)	2,375								(175,267)	17
18	Directors Fees													18
19	Professional Services	(20,560)	11,430	52,255	3,383								46,508	19
20	Fees, Subscriptions & Promotions	(25,565)		5,365	1,811								(18,389)	20
21	Clerical & General Office Expenses	(71,173)	1,996	140,679	37,905								109,407	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			754	1,021								1,775	24
25	Other Admin. Staff Transportation			7,527	383								7,910	25
26	Insurance-Prop.Liab.Malpractice		5,567	10									5,577	26
27	Other (specify):*			29,886	8,217								38,103	27
28	**TOTAL General Administration**	(117,298)	18,993	58,834	55,094								15,624	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(146,710)	18,993	247,873	77,386								197,542	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	(114,244)	127,196	5,644	711								19,307	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,825)	287,690	2,043	94								288,001	32
33	Real Estate Taxes		147,168	2,046	411								149,626	33
34	Rent-Facility & Grounds		(742,375)	1,530									(740,845)	34
35	Rent-Equipment & Vehicles			5,328	1,318								6,646	35
36	Other (specify):*	(24,817)	52,924										28,107	36
37	**TOTAL Ownership**	(140,886)	(127,397)	16,592	2,534								(249,158)	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):*	(3,089)											(3,089)	43
44	**TOTAL Special Cost Centers**	(3,089)											(3,089)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(290,686)	(108,404)	264,465	79,919								(54,706)	45

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 742,375	Monroe Pavilion Associates	100.00%	$	$ (742,375)	1
2	V	32	Interest	151	Monroe Pavilion Associates	100.00%	287,841	287,690	2
3	V	19	Accounting		Monroe Pavilion Associates	100.00%	10,990	10,990	3
4	V	36	Amortization		Monroe Pavilion Associates	100.00%	3,886	3,886	4
5	V	19	Data Processing		Monroe Pavilion Associates	100.00%	440	440	5
6	V	30	Depreciation		Monroe Pavilion Associates	100.00%	127,196	127,196	6
7	V	26	Insurance		Monroe Pavilion Associates	100.00%	5,567	5,567	7
8	V	36	MIP Expense		Monroe Pavilion Associates	100.00%	28,107	28,107	8
9	V	36	Entity Expense		Monroe Pavilion Associates	100.00%	20,931	20,931	9
10	V	21	IL Replacement Tax		Monroe Pavilion Associates	100.00%	1,996	1,996	10
11	V	33	Real Estate Tax		Monroe Pavilion Associates	100.00%	147,168	147,168	11
12	V								12
13	V								13
14	Total			$ 742,526			$ 634,122	$ * (108,404)	14

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 2,339	$ 2,339	15
16	V	6	MAINTENANCE SALARIES		NUCARE SERVICES CORP.	100.00%	10,354	10,354	16
17	V	6	MAINTENANCE EXPENSES		NUCARE SERVICES CORP.	100.00%	5,705	5,705	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		NUCARE SERVICES CORP.	100.00%	2,020	2,020	18
19	V	10	CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	141,093	141,093	19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		NUCARE SERVICES CORP.	100.00%	27,529	27,529	20
21	V	17	ADMINISTRATIVE SALARIES - NON-OWNER		NUCARE SERVICES CORP.	100.00%	31,877	31,877	21
22	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	52,255	52,255	22
23	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		NUCARE SERVICES CORP.	100.00%	5,365	5,365	23
24	V	21	CLERICAL & GENERAL SALARIES		NUCARE SERVICES CORP.	100.00%	121,299	121,299	24
25	V	21	CLERICAL & GENERAL EXPENSES		NUCARE SERVICES CORP.	100.00%	19,380	19,380	25
26	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	754	754	26
27	V	25	TRANSPORTATION		NUCARE SERVICES CORP.	100.00%	7,527	7,527	27
28	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	10	10	28
29	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		NUCARE SERVICES CORP.	100.00%	29,886	29,886	29
30	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	5,644	5,644	30
31	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,043	2,043	31
32	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	2,046	2,046	32
33	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	1,530	1,530	33
34	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	1,526	1,526	34
35	V	35	AUTO LEASE		NUCARE SERVICES CORP.	100.00%	3,802	3,802	35
36	V								36
37	V	17	BOOKKEEPING FEES	209,519	NUCARE SERVICES CORP.	100.00%		(209,519)	37
38	V								38
39	Total			$ 209,519			$ 473,984	$ * 264,465	39

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$	MAESTRO CONSULTING SERVICES LLC	100.00%	$ 92	$ 92	15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	1,509	1,509	16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	585	585	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	346	346	18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	16,081	16,081	19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	3,679	3,679	20
21	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	2,375	2,375	21
22	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	3,383	3,383	22
23	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	1,811	1,811	23
24	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	35,860	35,860	24
25	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	2,045	2,045	25
26	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,021	1,021	26
27	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	383	383	27
28	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	8,217	8,217	28
29	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	711	711	29
30	V	32	INTEREST EXPENSE		MAESTRO CONSULTING SERVICES LLC	100.00%	94	94	30
31	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	411	411	31
32	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	943	943	32
33	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	375	375	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 79,919	$ * 79,919	39

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 48,014	MAPLE LEAF	100.00%	$ 48,014	$	15
16	V	26	LIABILITY INSURANCE	202,492	MAPLE LEAF	100.00%	202,492		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			$ 250,506			$ 250,506	$ *	39

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	4.75%	SYMPHONY OF DECATUR	DECATUR	MONROE PAVILION ASSOCIAT	CHICAGO	BUILDING CO.	1
2	FEIGE KNOBEL DISCRETIONARY TRUST	1.58%	SYMPHONY OF DEERBROOK	JOLIET	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY INS	2
3	GERRY JENICH	5.00%	SYMPHONY OF COUNTRYSIDE	AURORA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	MARK HOLLANDER DISCRETIONARY TRUST	1.58%	SYMPHONY OF CRESTWOOD	CRESTWOOD	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	4
5	RAJCHENBACH FAMILY TRUST	4.75%	SYMPHONY OF MAPLE CREST	BELVIDERE	NUCARE SERVICES	LINCOLNWOOD	BOOKKEEPING	5
6	ROBERT HARTMAN	55.75%	SYMPHONY OF LINCOLN	LINCOLN	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	6
7	SHARON HOLLANDER DISCRETIONARY TRUST	1.58%	SYMPHONY OF MCKINLEY	DECATUR	DRAKE LOUIS ENTERPRISE	LINCOLNWOOD	MANAGEMENT CO.	7
8	DAVID HOKIN	25.00%	SYMPHONY OF NORTHWOODS	BELVIDERE	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME & MEDICAL SUPPLIES	8
9			SYMPHONY OF SYCAMORE	SWANSEA	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	9
10			SYMPHONY AT THE TILLERS	OSWEGO	MAESTRO CONSULTING SERVI	LINCOLNWOOD	MANAGEMENT CO.	10
11			SYMPHONY OF EVANSTON	EVANSTON				11
12			SEVEN OAKS	GLENDALE, WISCONSIN				12
13			SYMPHONY OF DYER	DYER, INDIANA				13
14			SYMPHONY OF CHESTERTON	CHESTERTON, INDIANA				14
15			SYMPHONY OF CROWN POINT	CROWN POINT, INDIANA				15
16			SYMPHONY ARIA	HILLSIDE				16
17			SYMPHONY BEVERLY	CHICAGO				17
18			SYMPHONY BRONZEVILLE	CHICAGO				18
19			SYMPHONY BUFFALO GROVE	BUFFALO GROVE				19
20			SYMPHONY IVY	CHICAGO				20
21			SYMPHONY JACKSON SQUARE	CHICAGO				21
22			SYMPHONY LINCOLN PARK	CHICAGO				22
23			SYMPHONY MIDWAY	CHICAGO				23
24			SYMPHONY PARK SOUTH	CHICAGO				24
25			SYMPHONY SOUTH SHORE	CHICAGO				25
26			CLAREMONT HANOVER PARK	HANOVER PARK				26
27			CALIFORNIA GARDENS	CHICAGO				27
28				CHICAGO				28
29								29
30								30

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,031,168	17	$ 58,329	$	41,344	$ 2,339	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,031,168	17	258,238	258,238	41,344	10,354	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,031,168	17	142,295		41,344	5,705	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,031,168	17	50,385		41,344	2,020	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,031,168	17	3,519,020	3,519,020	41,344	141,093	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,031,168	17	686,596		41,344	27,529	6
7	17	ADMINISTRATIVE SALARIES -	AVAIL. CENSUS DAYS	1,031,168	17	795,048	795,048	41,344	31,877	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,031,168	17	1,303,295		41,344	52,255	8
9	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,031,168	17	133,814		41,344	5,365	9
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,031,168	17	3,025,348	3,025,348	41,344	121,299	10
11	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,031,168	17	483,355		41,344	19,380	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,031,168	17	18,809		41,344	754	12
13	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,031,168	17	187,735		41,344	7,527	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	1,031,168	17	238		41,344	10	14
15	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,031,168	17	745,397		41,344	29,886	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,031,168	17	140,764		41,344	5,644	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,031,168	17	50,953		41,344	2,043	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,031,168	17	51,037		41,344	2,046	18
19	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,031,168	17	38,171		41,344	1,530	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,031,168	17	38,069		41,344	1,526	20
21	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,031,168	17	94,822		41,344	3,802	21
22										22
23										23
24										24
25	TOTALS					$ 11,821,715	$ 7,597,654		$ 473,984	25

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	307,257	28	$ 3,424	$	8,296	$ 92	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	307,257	28	55,893	55,893	8,296	1,509	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	307,257	28	21,648		8,296	585	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	307,257	28	12,799		8,296	346	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	307,257	28	595,582	595,582	8,296	16,081	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	307,257	28	136,244		8,296	3,679	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	307,257	28	87,954	2,420	8,296	2,375	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	307,257	28	125,288		8,296	3,383	8
9	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	307,257	28	67,058		8,296	1,811	9
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	307,257	28	1,328,131	1,328,131	8,296	35,860	10
11	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	307,257	28	75,756		8,296	2,045	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	307,257	28	37,815		8,296	1,021	12
13	25	TRANSPORTATION	AVAIL. CENSUS DAYS	307,257	28	14,185		8,296	383	13
14	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	307,257	28	304,341		8,296	8,217	14
15	30	DEPRECIATION	AVAIL. CENSUS DAYS	307,257	28	26,334		8,296	711	15
16	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	307,257	28	3,464		8,296	94	16
17	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	307,257	28	15,239		8,296	411	17
18	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	307,257	28	34,911		8,296	943	18
19	35	AUTO LEASE	AVAIL. CENSUS DAYS	307,257	28	13,885		8,296	375	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,959,951	$ 1,982,025		$ 79,919	25

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 48,014	1
2	26	LIABILITY INSURANCE	DIRECT ALLOCATION						202,492	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					$	$		$ 250,506	25

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD Loan		X	Mortgage			$	$ 5,567,974			$ 287,841	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit				455,382			27,464	6
7	Allocated from NuCare Serv	X									2,043	7
8	See Supplemental Schedule										94	8
9	TOTAL Facility Related						$	$ 6,023,356			$ 317,442	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,825)	10
11	Interest Income - Bldg Co.		X								(151)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,976)	14
15	TOTALS (line 9+line14)						$	$ 6,023,356			$ 315,465	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 28,107 **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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from Maestro Consult	X					$	$			$ 94	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										94	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 180,143	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.)		$ 168,802	2
3. Under or (over) accrual (line 2 minus line 1).		$ (11,341)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 174,662	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.**		$ 8,971	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** $ 20,679 **For** 2012 **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.		$ 172,292	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	144,652	8
	2011	144,050	9
	2012	176,490	10
	2013	171,564	11
	2014	166,345	12

2015 Accrual: $166,345 x 1.05 = $174,662

Allocated from NuCare Services Corp: $2,046

Allocated from Maestro Consulting Services: $411

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Monroe Pavilion Health 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 2014 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 2014.

	(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	$ 166,344.63	$ 166,344.63
2.	10-27-319-028-0000	Home Office Allocation	$ 91,415.94	$ 2,046.32
3.	10-27-319-028-0000	Home Office Allocation	$ 91,415.94	$ 1,039.37
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 349,176.51	$ 169,430.32

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Pavilion Health 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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 NuCare/Maestro 7257 N. Lincoln Ave			5,018	2
3	TOTALS	39,159		$ 35,482	3

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 127,196	26	$	$ (127,196)	$ 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			4,735	10
11	Various			1988	8,738		20			8,738	11
12	Various			1989	11,001		20			11,001	12
13	Various			1990	1,919		20			1,919	13
14	Various			1991	5,128		20			5,128	14
15	Various			1992	4,600		20			4,600	15
16	Various			1993	17,616		20			17,616	16
17	Various			1994	13,951		20	358	358	7,618	17
18	Various			1995	13,124		20	214	214	13,119	18
19	Various			1996	19,194		20	958	958	18,417	19
20	Various			1997	32,365		20	1,618	1,618	29,970	20
21	Various			1998	50,879		20	2,544	2,544	44,145	21
22	Various			1999	63,549		20	3,177	3,177	52,926	22
23	Various			2000	62,515		20	3,126	3,126	49,125	23
24	Various			2001	42,063		20	2,103	2,103	30,716	24
25	Various			2002	32,776		20	1,164	1,164	22,940	25
26	Various			2003	195,702		20	320	320	193,377	26
27	Various			2004	5,054		20	134	134	3,937	27
28	Various			2005	4,804		20	343	343	4,455	28
29	Various			2006	143,838		20	9,048	9,048	88,679	29
30	Various			2009	8,032		20	686	686	4,606	30
31	Various			2011	34,145		20	3,415	3,415	15,269	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	29,798	67
68	Related Party Allocations (Pages 12H & 12I)		99,929	2,914		2,524	(390)	38,340	68
69	Financial Statement Depreciation			34,267			(34,267)		69
70	TOTAL (lines 4 thru 69)		$ 3,119,787	$ 164,377		$ 36,449	$ (127,928)	$ 2,850,912	70

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 3,119,787	$ 164,377		$ 36,449	$ (127,928)	$ 2,850,912	1
2	Renovation 8 Common Bathrooms	2012	44,420		20	4,442	4,442	16,287	2
3	104 Pcs. Hand Rails For Stair Case	2012	3,500		20	350	350	1,108	3
4	Elevator Repair	2012	3,469		20	347	347	1,243	4
5	Boiler Repair	2012	5,920		20	592	592	2,368	5
6	Repair Elevator Door	2014	4,343		20	217	217	344	6
7	Water Pump Replacement	2015	3,397		20	283	283	283	7
8	Boiler - Wile Mcclain Model # 888-S Steam Boiler	2015	33,451		20	2,788	2,788	2,788	8
9	Door Improvements - Doors Done Right	2015	3,646		20	152	152	152	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)		$ 3,221,933	$ 164,377		$ 45,620	$ (118,757)	$ 2,875,485	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 3,221,933	$ 164,377		$ 45,620	$ (118,757)	$ 2,875,485	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)		$ 3,221,933	$ 164,377		$ 45,620	$ (118,757)	$ 2,875,485	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 3,221,933	$ 164,377		$ 45,620	$ (118,757)	$ 2,875,485	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)		$ 3,221,933	$ 164,377		$ 45,620	$ (118,757)	$ 2,875,485	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 3,221,933	$ 164,377		$ 45,620	$ (118,757)	$ 2,875,485	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)		$ 3,221,933	$ 164,377		$ 45,620	$ (118,757)	$ 2,875,485	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2004	5,493		20	275	275	4,480	9
10	Various	2005	11,502		20	574	574	9,209	10
11	Drapery Panel; Curtains	2007	19,724		20	986	986	7,888	11
12	Fire Pump	2013	49,072		20	2,454	2,454	7,361	12
13	Stairs Work	2014	8,600		20	430	430	860	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	$ 29,798	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 29,798	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)		$ 94,391	$		$ 4,719	$ 4,719	$ 29,798	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from NuCare 7257 N. Lincoln Ave	2004	38,683	826	35	921	95	13,401	3
4	Allocated from Maestro 7257 N. Lincoln Ave	2004	6,481	166	35	185	19	2,245	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from NuCare Services	2003	470	27	20	16	(11)	281	9
10	Allocated from NuCare Services	2004	9,535	554	20	318	(236)	5,594	10
11	Allocated from NuCare Services	2005	565	33	20	20	(13)	302	11
12	Allocated from NuCare Services	2006	766	45	20	27	(18)	353	12
13	Allocated from NuCare Services	2008	808	47	20	28	(19)	286	13
14	Allocated from NuCare Services	2009	13,007	756	20	452	(304)	4,190	14
15	Allocated from NuCare Services	2010	1,999	116	20	83	(33)	451	15
16	Allocated from NuCare Services	2011	108	6	20	4	(2)	26	16
17	Allocated from NuCare Services	2012	120	7	20	4	(3)	22	17
18	Allocated from NuCare Services	2014	1,503	87	20	52	(35)	108	18
19	Allocated from NuCare Services	2015	423		20	3	3	4	19
20									20
21	Allocated from NuCare 7257 N. Lincoln Ave	2015	610	25	20	11	(14)	14	21
22	Allocated from NuCare 7257 N. Lincoln Ave	2005	3,526	21	20	186	165	2,333	22
23	Allocated from NuCare 7257 N. Lincoln Ave	2004	769		20	32	32	442	23
24									24
25									25
26	Allocated from Maestro 7257 N. Lincoln Ave	2015	102	5	20	2	(3)	2	26
27	Allocated from Maestro 7257 N. Lincoln Ave	2005	591	4	20	37	33	391	27
28	Allocated from Maestro 7257 N. Lincoln Ave	2004	129		20	6	6	74	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 80,195	$ 2,725		$ 2,387	$ (338)	$ 30,519	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 80,195	$ 2,725		$ 2,387	$ (338)	$ 30,519	1
2									2
3	Leasehold Improvements:								3
4	Allocated from Maestro Consulting Services	2003	316	3	20	2	(1)	189	4
5	Allocated from Maestro Consulting Services	2004	6,421	62	20	43	(19)	3,767	5
6	Allocated from Maestro Consulting Services	2005	381	4	20	3	(1)	203	6
7	Allocated from Maestro Consulting Services	2006	516	5	20	4	(1)	237	7
8	Allocated from Maestro Consulting Services	2008	544	5	20	4	(1)	193	8
9	Allocated from Maestro Consulting Services	2009	8,759	85	20	61	(24)	2,822	9
10	Allocated from Maestro Consulting Services	2010	1,346	13	20	11	(2)	303	10
11	Allocated from Maestro Consulting Services	2011	73	1	20	1		17	11
12	Allocated from Maestro Consulting Services	2012	81	1	20	1		15	12
13	Allocated from Maestro Consulting Services	2014	1,012	10	20	7	(3)	73	13
14	Allocated from Maestro Consulting Services	2015	285		20			2	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)		$ 99,929	$ 2,914		$ 2,524	$ (390)	$ 38,340	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 311,625	$ 3,002	$ 7,354	$ 4,352	10	$ 194,225	71
72	Current Year Purchases	10,755	415	506	91	10	897	72
73	Fully Depreciated Assets	218,928		53	53	10	218,928	73
74								74
75	TOTALS	$ 541,308	$ 3,417	$ 7,913	$ 4,496		$ 414,050	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 Services (	2015	355	21	35	14	5	355	77
78		Allocated from Maestro Consultir	2015	239	2	5	3	5	239	78
79										79
80	TOTALS			$ 2,794	$ 23	$ 40	$ 17		$ 594	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)	$ 3,801,517	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 167,817	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 53,573	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (114,244)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,290,129	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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Allocated from NuCare Services Corp				1,530			5
6								6
7	TOTAL				$ 1,530 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 19,222 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 Services Corp		$	$ 3,802	17
18	Allocated from Maestro Consulting			375	18
19					19
20					20
21	TOTAL		$	$ 4,177	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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		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	39 - 02	# of prescrpts				259		259	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						177		177	13
14	TOTAL			$		$	$ 436		$ 436	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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 79,246	$ 99,091	1
2	Cash-Patient Deposits	33,181	33,181	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,003,233	2,004,899	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	988	2,512	6
7	Other Prepaid Expenses	2,696	2,696	7
8	Accounts Receivable (owners or related parties)		55,935	8
9	Other(specify):		304,928	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,119,344	$ 2,503,242	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	815,658	3,267,786	15
16	Equipment, at Historical Cost	423,260	703,136	16
17	Accumulated Depreciation (book methods)	(1,057,329)	(4,282,133)	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):		235,506	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 181,589	$ 2,478,331	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,300,933	$ 4,981,573	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,772,369	$ 1,772,809	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,668	1,668	28
29	Short-Term Notes Payable	455,382	578,051	29
30	Accrued Salaries Payable	186,962	186,962	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,643	12,643	31
32	Accrued Real Estate Taxes(Sch.IX-B)		174,662	32
33	Accrued Interest Payable		23,757	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	8,465	8,465	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,437,489	$ 2,759,017	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,445,305	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,445,305	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,437,489	$ 8,204,322	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (136,556)	$ (3,222,749)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,300,933	$ 4,981,573	48

*(See instructions.)

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 413,610	1
2	Restatements (describe):		2
3	**Workers Compensation**	(639)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 412,971	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(549,527)	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)**	$ (549,527)	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)**	$ (136,556)	24 *

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 4,190,394	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,190,394	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		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,825	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,825	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	20,689	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 20,689	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,212,908	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,043,428	31
32	Health Care	1,680,078	32
33	General Administration	1,200,849	33
	B. Capital Expense		
34	Ownership	834,555	34
	C. Ancillary Expense		
35	Special Cost Centers	3,525	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)***	$ 4,762,435	40
41	**Income before Income Taxes (line 30 minus line 40)****	(549,527)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (549,527)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,808,725	44
45	Private Pay - Net Inpatient Revenue	5,424	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Veterans	376,245	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,190,394	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 Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,945	2,062	$ 80,351	$ 38.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,545	2,669	81,618	30.58	3
4	Licensed Practical Nurses	21,704	23,415	559,457	23.89	4
5	CNAs & Orderlies	40,583	45,609	538,519	11.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,894	2,086	32,189	15.43	9
10	Activity Assistants	3,265	3,794	41,148	10.85	10
11	Social Service Workers	8,724	9,839	183,298	18.63	11
12	Dietician					12
13	Food Service Supervisor	1,885	2,126	51,344	24.15	13
14	Head Cook	4,758	5,531	57,681	10.43	14
15	Cook Helpers/Assistants	8,501	9,498	105,365	11.09	15
16	Dishwashers					16
17	Maintenance Workers	1,909	2,086	32,359	15.51	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,228	2,399	95,118	39.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,853	2,097	43,469	20.73	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	1,916	2,128	39,516	18.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	103,710	115,339	$ 1,941,432 *	$ 16.83	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	$ 6,868	01-03	35
36	Medical Director	Monthly	25,851	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	1,484	10-03	38
39	Pharmacist Consultant	Monthly	9,651	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	1,430	11-03	44
45	Social Service Consultant				45
46	Other(specify) Dental	Monthly	4,830	10 - 03	46
47	Art Therapy	53	2,896	11 - 03	47
48	Psychiatric MD	Monthly	330	10 - 03	48
49	TOTAL (lines 35 - 48)	223	$ 53,340		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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Williams	Administrator	0.00%	$ 95,118
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,118

B. Administrative - Other

Description	Amount
NuCare Services Corp - Bookkeeping Fees	$ 209,519
TOTAL (agree to Schedule V, line 17, col. 3)	$ 209,519
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R/Marcum LLP	Accounting	$ 16,130
RFMS	Cost Management	2,690
Personnel Planners	Unemployment Tax Consult	1,146
Creative Technology	Data Processing	3,479
E-Health Data Solutions	Data Processing	3,400
Matrixcare	Data Processing	6,510
Wescom Solutions	Data Processing	16,457
See Attached	Legal	46,335
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 96,147

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,171
Unemployment Compensation Insurance	50,306
FICA Taxes	144,868
Employee Health Insurance	100,151
Employee Meals	11,081
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan Contributions	4,959
Employee Physical Exams	1,233
Other Employee Benefits	8,169
TOTAL (agree to Schedule V, line 22, col.8)	$ 402,939

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	$ 1,837
Advertising: Employee Recruitment	290
Health Care Worker Background Check	1,223
(Indicate # of checks performed 53)	
Patient Background Checks 122	3,010
Dues and Subscriptions	19,996
License and Permits	2,775
Allocated from NuCare Services Corp	5,365
Allocated from Maestro Consulting	1,811
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,307

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,355
Allocated from NuCare Services Corp	754
Allocated from Maestro Consulting	1,021
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,130

**See instructions.

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0040071 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Pavilion Health Ctr. # 0040071 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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 $17,640 & IL Council LTC $10,000**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **57** Line **10**

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

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

(9) Are you presently operating under a sublease agreement? **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/A** 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. $ **11,081** 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.