		FOR BHF USE					

LL1

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

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0040071

Facility Name: Monroe Pav Hlth Treatmnt Ctr

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 7/1/1994

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) * (Date)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 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 Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	49,776	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	136	TOTALS	136	49,776	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	40,802		2,613	43,415	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,802		2,613	43,415	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.22%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/1994 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	219,386	15,273	6,858	241,517		241,517		241,517			1
2	Food Purchase		179,838		179,838	(10,468)	169,370		169,370			2
3	Housekeeping		149,065		149,065		149,065		149,065			3
4	Laundry		86,812		86,812		86,812		86,812			4
5	Heat and Other Utilities			182,398	182,398		182,398	270	182,668			5
6	Maintenance	37,590		193,156	230,746		230,746	21,054	251,800			6
7	Other (specify):*							2,307	2,307			7
8	TOTAL General Services	256,976	430,988	382,412	1,070,376	(10,468)	1,059,908	23,631	1,083,539			8
	B. Health Care and Programs											
9	Medical Director			19,920	19,920		19,920		19,920			9
10	Nursing and Medical Records	1,270,424	71,278	62,232	1,403,934		1,403,934	65,486	1,469,420			10
10a	Therapy											10a
11	Activities	58,836	3,283	2,420	64,539		64,539		64,539			11
12	Social Services	154,862			154,862		154,862		154,862			12
13	CNA Training											13
14	Program Transportation			850	850		850	(49)	801			14
15	Other (specify):*							13,777	13,777			15
16	TOTAL Health Care and Programs	1,484,122	74,561	85,422	1,644,105		1,644,105	79,214	1,723,319			16
	C. General Administration											
17	Administrative	106,858		236,047	342,905		342,905	(210,767)	132,138			17
18	Directors Fees											18
19	Professional Services			236,818	236,818	(7,889)	228,929	9,783	238,711			19
20	Dues, Fees, Subscriptions & Promotions			61,053	61,053		61,053	(17,684)	43,369			20
21	Clerical & General Office Expenses	93,285	1,462	823,389	918,136		918,136	(580,667)	337,469			21
22	Employee Benefits & Payroll Taxes			424,293	424,293	10,468	434,761		434,761			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,165	2,165		2,165	825	2,990			24
25	Other Admin. Staff Transportation			205	205		205	2,045	2,250			25
26	Insurance-Prop.Liab.Malpractice			155,550	155,550		155,550	10,260	165,810			26
27	Other (specify):*							31,841	31,841			27
28	TOTAL General Administration	200,143	1,462	1,939,520	2,141,125	2,578	2,143,703	(754,364)	1,389,340			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,941,241	507,011	2,407,354	4,855,606	(7,889)	4,847,717	(651,519)	4,196,198			29

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr #0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			30,102	30,102		30,102	17,832	47,934			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,561	21,561		21,561	272,480	294,041			32
33	Real Estate Taxes			7,408	7,408	7,889	15,297	212,889	228,186			33
34	Rent-Facility & Grounds			632,204	632,204		632,204	(628,103)	4,101			34
35	Rent-Equipment & Vehicles			14,873	14,873		14,873	3,981	18,854			35
36	Other (specify):*							27,508	27,508			36
37	**TOTAL Ownership**			706,148	706,148	7,889	714,037	(93,413)	620,624			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):*			69,789	69,789		69,789	(69,789)	0			43
44	**TOTAL Special Cost Centers**			69,789	69,789		69,789	(69,789)	0			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,941,241	507,011	3,183,291	5,631,543		5,631,543	(814,721)	4,816,822			45

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,137)	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	(110,544)	30		9
10	Interest and Other Investment Income	(9,075)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,281)	21		18
19	Entertainment				19
20	Contributions	(10,450)	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	(752,008)	21		24
25	Fund Raising, Advertising and Promotional	(374)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(156,007)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,041,876)		$	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)	227,155		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 227,155		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (814,721)		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 Pav Hlth Treatmnt Ctr

ID# 0040071

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Pharmacy - Veteran	$ (21,968)	10	1
2	Laboratory - Veteran	(1,133)	10	2
3	Other Income	(50)	21	3
4	Discounts	(3)	21	4
5	Bank Charges	(12,128)	21	5
6	Marketing Consultant	(59,841)	43	6
7	Marketing Services	(8,849)	43	7
8	Additional R&M	5,250	06	8
9	Building Company - Accounting	(12,283)	19	9
10	Building Company - Amortization	(3,886)	36	10
11	Building Company - Data Processing	(440)	19	11
12	Building Company - License & Permits	(150)	20	12
13	Building Company - Closing Expenses	(84)	21	13
14	Building Company - Penalties	(4,724)	21	14
15	Building Company - Professional Fees	(271)	19	15
16	Alliance for Living PAC Dues	(8,555)	20	16
17	Non-allowable Legal	(985)	19	17
18	Marketing - Data Processing	(1,099)	43	18
19	P.P. - General and Administrative	(964)	21	19
20	P.P. - Data Processing	(9,654)	19	20
21	Annual Report	(457)	19	21
22	P.P. - Professional Fees	(4,759)	19	22
23	P.P. - Dues and Subscriptions	(8,820)	20	23
24	Patient Needs	(154)	10	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**	(156,007)		49

Monroe Pav Hlth Treatmnt Ctr

ID# 0040071

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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 Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(1,137)		1,407									270	5
6	Maintenance	5,250		15,804									21,054	6
7	Other (specify):*			2,307									2,307	7
8	**TOTAL General Services**	4,113		19,518									23,631	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(23,255)		88,741									65,486	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation					(49)							(49)	14
15	Other (specify):*			13,777									13,777	15
16	**TOTAL Health Care and Programs**	(23,255)		102,518		(49)							79,214	16
	C. General Administration													
17	Administrative			(210,767)									(210,767)	17
18	Directors Fees													18
19	Professional Services	(28,849)	12,994	25,638									9,783	19
20	Fees, Subscriptions & Promotions	(28,349)	150	10,515									(17,684)	20
21	Clerical & General Office Expenses	(772,242)	4,808	186,767									(580,667)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			825									825	24
25	Other Admin. Staff Transportation			2,045									2,045	25
26	Insurance-Prop.Liab.Malpractice		7,869	2,391									10,260	26
27	Other (specify):*			31,841									31,841	27
28	**TOTAL General Administration**	(829,440)	25,821	49,255									(754,364)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(848,582)	25,821	171,291		(49)							(651,519)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(110,544)	127,112	1,264									17,832	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,075)	281,555										272,480	32
33	Real Estate Taxes		209,747	3,142									212,889	33
34	Rent-Facility & Grounds		(632,204)	4,101									(628,103)	34
35	Rent-Equipment & Vehicles			3,981									3,981	35
36	Other (specify):*	(3,886)	31,394										27,508	36
37	TOTAL Ownership	(123,505)	17,604	12,488									(93,413)	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):*	(69,789)											(69,789)	43
44	TOTAL Special Cost Centers	(69,789)											(69,789)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,041,876)	43,425	183,779		(49)							(814,721)	45

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 632,204	Monroe Pavilion Associates	100.00%	$	$ (632,204)	1
2	V	32	Interest	150	Monroe Pavilion Associates	100.00%	281,705	281,555	2
3	V	19	Accounting Fees		Monroe Pavilion Associates	100.00%	12,283	12,283	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%	127,112	127,112	6
7	V	26	Insurance		Monroe Pavilion Associates	100.00%	7,869	7,869	7
8	V	36	MIP Expense		Monroe Pavilion Associates	100.00%	27,508	27,508	8
9	V	20	License and Permits		Monroe Pavilion Associates	100.00%	150	150	9
10	V	21	Closing Expense		Monroe Pavilion Associates	100.00%	84	84	10
11	V	21	Penalties		Monroe Pavilion Associates	100.00%	4,724	4,724	11
12	V	19	Professional Fees		Monroe Pavilion Associates	100.00%	271	271	12
13	V	33	Real Estate Taxes		Monroe Pavilion Associates	100.00%	209,747	209,747	13
14	Total			$ 632,354			$ 675,779	$ * 43,425	14

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	$ 1,407	$ 1,407	15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	12,884	12,884	16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	2,920	2,920	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	2,307	2,307	18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	88,741	88,741	19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	13,777	13,777	20
21	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	25,280	25,280	21
22	V	17	ADMINISTRATIVE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%			22
23	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	25,638	25,638	23
24	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	10,515	10,515	24
25	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	166,086	166,086	25
26	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	20,681	20,681	26
27	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	825	825	27
28	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	2,045	2,045	28
29	V	26	INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	2,391	2,391	29
30	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	31,841	31,841	30
31	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,264	1,264	31
32	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	3,142	3,142	32
33	V	34	BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	4,101	4,101	33
34	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	1,773	1,773	34
35	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	2,208	2,208	35
36	V								36
37	V	17	BOOKKEEPING FEES	236,047	MAESTRO CONSULTING SERVICES LLC	100.00%		(236,047)	37
38	V								38
39	Total			$ 236,047			$ 419,826	$ * 183,779	39

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 107,049	MAPLE LEAF	100.00%	$ 107,049	$	15
16	V	26	LIABILITY INSURANCE	148,310	MAPLE LEAF	100.00%	148,310		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			$ 255,359			$ 255,359	$ *	39

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	14	Transportation	$ 371	Lifeline Ambulance LLC		$ 322	$ (49)	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			$ 371			$ 322	$ * (49)	39

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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%	CALIFORNIA GARDENS	CHICAGO	MONROE PAVILION ASSOCIAT	CHICAGO	BUILDING CO.	1
2	FEIGE KNOBEL DISCRETIONARY TRUST	1.58%	MAPLECREST CARE CENTRE	BELVIDERE	MAESTRO CONSULTING SERVI	LINCOLNWOOD	MANAGEMENT	2
3	GERRY JENICH	5.00%	MCKINLEY COURT	DECATUR	7257 N. LINCOLN AVENUE	LINCOLNWOOD	BUILDING RENTAL	3
4	MARK HOLLANDER DISCRETIONARY TRUST	1.58%	NORTHWOODS CARE CENTRE	BELVIDERE	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY/WORK COMP IN	4
5	RAJCHENBACH FAMILY TRUST	4.75%	SYCAMORE VILLAGE	SWANSEA	INTEGRA HEALTHCARE EQUI	ELMHURST	DME & MEDICAL SUPPLIES	5
6	ROBERT HARTMAN	55.75%	SYMPHONY ARIA	HILLSIDE	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY SERVICES	6
7	SHARON HOLLANDER DISCRETIONARY TRUST	1.58%	SYMPHONY AT 87TH STREET	CHICAGO	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	7
8	FAIRHOME TRUST U/A/D 12/31/12	25.00%	SYMPHONY AT MIDWAY	CHICAGO				8
9			SYMPHONY AT THE TILLERS	OSWEGO				9
10			SYMPHONY OF BRONZEVILLE	CHICAGO				10
11			SYMPHONY OF BUFFALO GROVE	BUFFALO GROVE				11
12			SYMPHONY OF CHESTERTON	CHESTERTON, IN				12
13			SYMPHONY OF CHICAGO WEST	CHICAGO				13
14			SYMPHONY OF CRESTWOOD	CRESTWOOD				14
15			SYMPHONY OF CROWN POINT	CROWN POINT, IN				15
16			SYMPHONY OF DECATUR	DECATUR				16
17			SYMPHONY OF DYER	DYER, IN				17
18			SYMPHONY OF EVANSTON	EVANSTON				18
19			SYMPHONY OF GLENDALE	GLENDALE, WI				19
20			SYMPHONY OF HANOVER PARK	HANOVER PARK				20
21			SYMPHONY OF JOLIET	JOLIET				21
22			SYMPHONY OF LINCOLN	LINCOLN				22
23			SYMPHONY OF LINCOLN PARK	CHICAGO				23
24			SYMPHONY OF MORGAN PARK	CHICAGO				24
25			SYMPHONY OF ORCHARD VALLEY	AURORA				25
26			SYMPHONY OF SOUTH SHORE	CHICAGO				26
27			SYMPHONY RESIDENCES OF LINCOLN PARK	CHICAGO				27
28								28
29								29
30								30

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,836,222	28	$ 51,919	$	49,776	$ 1,407	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	475,288	475,288	49,776	12,884	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28	107,711		49,776	2,920	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,836,222	28	85,090		49,776	2,307	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	3,273,643	3,273,643	49,776	88,741	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,836,222	28	508,220		49,776	13,777	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,836,222	28	932,558	932,558	49,776	25,280	7
8	17	ADMINISTRATIVE EXPENSES	AVAIL. CENSUS DAYS	1,836,222	28			49,776		8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,836,222	28	945,768		49,776	25,638	9
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,836,222	28	387,900		49,776	10,515	10
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,836,222	28	6,126,863	6,126,863	49,776	166,086	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,836,222	28	762,920		49,776	20,681	12
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,836,222	28	30,439		49,776	825	13
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,836,222	28	75,434		49,776	2,045	14
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,836,222	28	88,214		49,776	2,391	15
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,836,222	28	1,174,614		49,776	31,841	16
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,836,222	28	46,621		49,776	1,264	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,836,222	28	115,912		49,776	3,142	18
19	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	151,288		49,776	4,101	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,836,222	28	65,399		49,776	1,773	20
21	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,836,222	28	81,453		49,776	2,208	21
22										22
23										23
24										24
25	TOTALS					$ 15,487,256	$ 10,808,353		$ 419,826	25

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$	$		$ 107,049	1
2	26	LIABILITY INSURANCE	Direct Allocation						148,310	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					$	$		$ 255,359	25

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	14	Transportation	Direct Allocation			$	$		$ 322	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					$	$		$ 322	25

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD Loan		X	Mortgage			$	$ 5,517,623			$ 281,705	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	Private Bank		X	Line of Credit				905,382			21,561	6
7												7
8					-							8
9	TOTAL Facility Related						$	$ 6,423,005			$ 303,266	9
	B. Non-Facility Related*											
10	Interest Income		X								(9,075)	10
11	Bldg. Co. - Interest Income		X								(150)	11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (9,225)	14
15	TOTALS (line 9+line14)						$	$ 6,423,005			$ 294,041	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 27,508 Line # 36

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr **#** 0040071 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	188,357	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.)	$	190,659	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,302	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	217,995	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.)**	$	7,889	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	228,186	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	144,050	8
	2012	176,490	9
	2013	171,564	10
	2014	166,345	11
	2015	187,516	12

Beginning Accrual Adjusted
2016 Accural - $187,516 x 1.162 = $217,995 (Rounded)
Allocated - Maestro Consulting - $3,142

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Monroe Pav Hlth Treatmnt Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040071

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-17-102-043-0000	Long Term Care Property	$ 187,516.41	$ 187,516.41
2.	10-27-319-028-0000	Allocated - Maestro 7257 Lincoln	$ 95,270.31	$ 2,582.57
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 282,786.72	$ 190,098.98

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Monroe Pav Hlth Treatmnt Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040071

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 - Maestro 7257 Lincoln			4,337	2
3	TOTALS	39,159		$ 34,801	3

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 127,112	26	$	$ (127,112)	$ 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	7,976	17
18	Various			1995	13,124		20			13,119	18
19	Various			1996	19,194		20	540	540	18,957	19
20	Various			1997	32,365		20	1,618	1,618	31,588	20
21	Various			1998	50,879		20	2,544	2,544	46,689	21
22	Various			1999	63,549		20	3,177	3,177	56,104	22
23	Various			2000	62,515		20	3,126	3,126	52,250	23
24	Various			2001	42,063		20	2,103	2,103	32,819	24
25	Various			2002	32,776		20	1,164	1,164	24,104	25
26	Various			2003	195,702		20	320	320	193,697	26
27	Various			2004	5,054		20	134	134	4,071	27
28	Various			2005	4,804		20	35	35	4,490	28
29	Various			2006	143,838		20	7,141	7,141	95,819	29
30	Various			2009	8,032		20	685	685	5,291	30
31	Various			2011	34,145		20	3,415	3,415	18,683	31
32	Various			2012	57,309		20	5,731	5,731	26,738	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	34,517	67
68	Related Party Allocations (Pages 12H & 12I)		65,048	1,133		2,364	1,231	26,719	68
69	Financial Statement Depreciation			30,102			(30,102)		69
70	TOTAL (lines 4 thru 69)		$ 3,142,215	$ 158,347		$ 39,172	$ (119,175)	$ 2,897,106	70

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,142,215	$ 158,347		$ 39,172	$ (119,175)	$ 2,897,106	1
2	Repair Elevator Door	2014	4,343		20	217	217	561	2
3	Water Pump Replacement	2015	3,397		20	679	679	963	3
4	Boiler - Wile Mcclain Model # 888-S Steam Boiler	2015	33,451		20	1,673	1,673	3,345	4
5	Door Improvements - Doors Done Right	2015	3,646		20	182	182	258	5
6	Galvanized Steel Insulated Door	2016	8,484		20	71	71	71	6
7	Elevator - Installed New Cylinder	2016	36,800		20	460	460	460	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)		$ 3,232,336	$ 158,347		$ 42,454	$ (115,893)	$ 2,902,764	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,232,336	$ 158,347		$ 42,454	$ (115,893)	$ 2,902,764	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)		$ 3,232,336	$ 158,347		$ 42,454	$ (115,893)	$ 2,902,764	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,232,336	$ 158,347		$ 42,454	$ (115,893)	$ 2,902,764	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)		$ 3,232,336	$ 158,347		$ 42,454	$ (115,893)	$ 2,902,764	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,232,336	$ 158,347		$ 42,454	$ (115,893)	$ 2,902,764	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)		$ 3,232,336	$ 158,347		$ 42,454	$ (115,893)	$ 2,902,764	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2004	5,493		20	275	275	4,755	9
10	Various	2005	11,502		20	574	574	9,783	10
11	Drapery Panel; Curtains	2007	19,724		20	986	986	8,874	11
12	Fire Pump	2013	49,072		20	2,454	2,454	9,815	12
13	Stairs Work	2014	8,600		20	430	430	1,290	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	$ 34,517	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 34,517	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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	$ 34,517	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 - Maestro 7257 Lincoln	2004	39,035	1,001	35	1,115	114	14,638	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - Maestro Consulting	2003	318		20	16	16	208	9
10	Allocated - Maestro Consulting	2004	6,446		20	350	350	4,102	10
11	Allocated - Maestro Consulting	2005	382		20	19	19	226	11
12	Allocated - Maestro Consulting	2006	518		20	26	26	269	12
13	Allocated - Maestro Consulting	2008	546		20	27	27	226	13
14	Allocated - Maestro Consulting	2009	8,794		20	413	413	3,346	14
15	Allocated - Maestro Consulting	2010	1,351		20	68	68	440	15
16	Allocated - Maestro Consulting	2011	73		20	4	4	22	16
17	Allocated - Maestro Consulting	2012	81		20	4	4	19	17
18	Allocated - Maestro Consulting	2014	1,016		20	51	51	133	18
19	Allocated - Maestro Consulting	2015	286		20	14	14	19	19
20	Allocated - Maestro Consulting	2016	1,253	49	20	49		49	20
21									21
22	Allocated - Maestro 7257 Lincoln	2015	615	58	20	41	(17)	55	22
23	Allocated - Maestro 7257 Lincoln	2005	3,558	25	20	128	103	2,482	23
24	Allocated - Maestro 7257 Lincoln	2004	776		20	39	39	485	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)		$ 65,048	$ 1,133		$ 2,364	$ 1,231	$ 26,719	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 65,048	$ 1,133		$ 2,364	$ 1,231	$ 26,719	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 65,048	$ 1,133		$ 2,364	$ 1,231	$ 26,719	34

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 249,039	$	$ 5,275	$ 5,275	10	$ 157,260	71
72	Current Year Purchases	1,176	131	113	(18)	10	134	72
73	Fully Depreciated Assets	223,197		92	92	10	237,917	73
74								74
75	TOTALS	$ 473,412	$ 131	$ 5,480	$ 5,349		$ 395,311	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 - Maestro Consulting	2016	240				5	240	77
78										78
79										79
80	TOTALS			$ 2,440	$	$	$		$ 240	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)	$ 3,742,990	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 158,478	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 47,934	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (110,544)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,298,315	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	Various Improvements	$ 11,040	92
93			93
94			94
95		$ 11,040	95

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 - Maestro Consutling				4,101			5
6								6
7	TOTAL				$ 4,101 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 16,646 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 - Maestro Consulting		$	$ 2,208	17
18					18
19					19
20					20
21	TOTAL		$ -	$ 2,208	21

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	14

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr **#** 0040071 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 2,000	$ 2,000	1
2	Cash-Patient Deposits	33,181	33,181	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,026,952	3,028,618	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,585	8,162	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		173,269	8
9	Other(specify):		134,696	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,069,718	$ 3,379,926	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	849,902	3,302,030	15
16	Equipment, at Historical Cost	428,510	708,386	16
17	Accumulated Depreciation (book methods)	(1,087,431)	(4,439,347)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	11,040	660,842	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 202,021	$ 2,785,947	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,271,739	$ 6,165,873	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,202,248	$ 3,219,795	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,668	1,668	28
29	Short-Term Notes Payable	905,382	905,382	29
30	Accrued Salaries Payable	147,886	147,886	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,818	27,818	31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,103	217,995	32
33	Accrued Interest Payable		187,106	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)**	$ 4,314,570	$ 4,716,115	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,517,623	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)**	$	$ 5,517,623	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,314,570	$ 10,233,738	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,042,831)	$ (4,067,865)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,271,739	$ 6,165,873	48

***(See instructions.)**

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (136,556)	1
2	Restatements (describe):		2
3	**Hospital Insurance**	(45,929)	3
4	**Rounding**	4	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (182,481)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(860,350)	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)**	$ (860,350)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,042,831)	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,762,045	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,762,045	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	20	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)**	$ 20	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,075	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,075	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	53	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 53	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,771,193	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,070,376	31
32	Health Care	1,644,105	32
33	General Administration	2,141,125	33
	B. Capital Expense		
34	Ownership	706,148	34
	C. Ancillary Expense		
35	Special Cost Centers	69,789	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)***	$ 5,631,543	40
41	**Income before Income Taxes (line 30 minus line 40)****	(860,350)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (860,350)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,912,698	44
45	Private Pay - Net Inpatient Revenue	106,558	45
46	Medicare - Net Inpatient Revenue	41,493	46
47	Other-(specify) Veteran	335,196	47
48	Other-(specify) Managed Care	366,100	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,762,045	49

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

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

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

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,026	2,131	$ 86,055	$ 40.38	1
2	Assistant Director of Nursing	609	640	22,406	35.01	2
3	Registered Nurses	4,963	4,996	154,483	30.92	3
4	Licensed Practical Nurses	20,115	21,470	513,046	23.90	4
5	CNAs & Orderlies	35,520	39,178	469,235	11.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,018	2,091	34,068	16.29	9
10	Activity Assistants	1,816	2,047	24,768	12.10	10
11	Social Service Workers	8,368	8,941	154,862	17.32	11
12	Dietician					12
13	Food Service Supervisor	1,712	1,909	46,916	24.58	13
14	Head Cook	4,914	5,466	66,582	12.18	14
15	Cook Helpers/Assistants	8,079	9,001	105,888	11.76	15
16	Dishwashers					16
17	Maintenance Workers	2,034	2,251	37,590	16.70	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,986	2,091	106,858	51.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,350	4,133	93,285	22.57	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	1,225	1,352	25,199	18.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	98,735	107,697	$ 1,941,241 *	$ 18.03	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	$ 6,858	01-03	35
36	Medical Director	Monthly	19,920	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	13,747	10-03	38
39	Pharmacist Consultant	Monthly	33,042	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,420	11-03	44
45	Social Service Consultant				45
46	Other(specify) Dental	Monthly	4,410	10-03	46
47					47
48	Psychiatric	Monthly	11,033	10-03	48
49	TOTAL (lines 35 - 48)	188	$ 91,430		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Williams	Administrator	0	$ 106,858
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,858

B. Administrative - Other

Description	Amount
Maestro Consulting - Bookkeeping Fees	$ 236,047
TOTAL (agree to Schedule V, line 17, col. 3)	$ 236,047
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal	See Attached	$ 33,654
Marcum	Accounting	49,603
Ability	Network Service Vendor	2,145
Creative Technology	Data Processing	17,095
Dart Chart	Reimbursement Software	44
EMMI Solutions	Patient Engagement	89
Formation Healthcare Group	Risk Management	482
Health Data Systems	Payroll Processing	5,176
Matrixcare	E.H.R.	1,872
Ventiv Technology	Claims Assistance	1,575
Point Click Care	Data Processing	17,414
See Supplemental Schedule		107,669
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 236,818

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,049
Unemployment Compensation Insurance	41,534
FICA Taxes	139,343
Employee Health Insurance	120,286
Employee Meals	10,468
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	12,667
Employee Benefits - Other	1,620
Employee Physicals	1,795
TOTAL (agree to Schedule V, line 22, col.8)	$ 434,762

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	8,675
(Indicate # of checks performed 373)	
Patient Background Checks 93	2,304
Dues & Subcriptions	13,845
Licenses and Permits	6,040
Allocated - Maestro Consulting	10,515
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,368

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,165
Allocated - Maestro Consulting	825
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,990

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/16 Ending: 12/31/16

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**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **None** Line **N/A**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **10,468** 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 fo
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 1**
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
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