

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: <u>0040071</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Monroe Pavilion Health Ctr.</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> 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.	
Address: <u>1400 West Monroe</u> <u>Chicago</u> <u>60607</u>			
NumberCityZip Code			
County: <u>Cook</u>			
Telephone Number: <u>(312) 666-4090</u> Fax # <u>(312) 421-0134</u>			
HFS ID Number: <u>363961690001</u>		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>07/01/94</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code <u> </u> ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☒ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other <u> </u> ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other <u> </u>			
In the event there are further questions about this report, please contact:			
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: <u>slavenda@frrcpas.com</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health Ctr.

0040071 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	45,831	44	3,263	49,138	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,831	44	3,263	49,138	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.72%

D. How many bed-hold days during this year were paid by the Department? 160 (Do not include bed-hold days in Section B.)

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 07/1/1994

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	201,284	16,382	6,968	224,634		224,634		224,634			1
2	Food Purchase		187,007		187,007	(9,662)	177,345	(2)	177,343			2
3	Housekeeping		1,375	115,516	116,891		116,891		116,891			3
4	Laundry		6,071	77,011	83,082		83,082		83,082			4
5	Heat and Other Utilities			112,516	112,516		112,516	431	112,947			5
6	Maintenance	41,897	21,663	75,878	139,438		139,438	(527)	138,911			6
7	Other (specify):*											7
8	TOTAL General Services	243,181	232,498	387,889	863,568	(9,662)	853,906	(97)	853,809			8
	B. Health Care and Programs											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	1,495,876	90,937	6,659	1,593,472		1,593,472	(41,532)	1,551,940			10
10a	Therapy											10a
11	Activities	93,668	8,655	1,504	103,827		103,827	302	104,129			11
12	Social Services	67,964		1,785	69,749		69,749		69,749			12
13	CNA Training											13
14	Program Transportation			972	972		972		972			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,657,508	99,592	37,920	1,795,020		1,795,020	(41,230)	1,753,790			16
	C. General Administration											
17	Administrative	69,495		291,701	361,196		361,196	(272,480)	88,716			17
18	Directors Fees											18
19	Professional Services			67,283	67,283	(67)	67,216	871	68,087			19
20	Dues, Fees, Subscriptions & Promotions			51,417	51,417		51,417	(41,294)	10,123			20
21	Clerical & General Office Expenses	64,791	15,588	49,397	129,776		129,776	91,432	221,208			21
22	Employee Benefits & Payroll Taxes			354,976	354,976	9,662	364,638		364,638			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,011	5,011		5,011	(2,484)	2,527			24
25	Other Admin. Staff Transportation							950	950			25
26	Insurance-Prop.Liab.Malpractice			300,824	300,824		300,824	6,046	306,870			26
27	Other (specify):*							25,023	25,023			27
28	TOTAL General Administration	134,286	15,588	1,120,609	1,270,483	9,595	1,280,078	(191,935)	1,088,143			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,034,975	347,678	1,546,418	3,929,071	(67)	3,929,004	(233,262)	3,695,742			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			44,467	44,467		44,467	11,626	56,093			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,502	30,502		30,502	305,250	335,752			32
33	Real Estate Taxes					67	67	146,314	146,381			33
34	Rent-Facility & Grounds			1,199,630	1,199,630		1,199,630	(1,199,365)	265			34
35	Rent-Equipment & Vehicles			10,590	10,590		10,590	3,248	13,838			35
36	Other (specify):*							29,732	29,732			36
37	TOTAL Ownership			1,285,189	1,285,189	67	1,285,256	(703,196)	582,060			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			521,404	521,404		521,404	(149,140)	372,264			42
43	Other (specify):*			60,595	60,595		60,595	(60,595)				43
44	TOTAL Special Cost Centers			581,999	581,999		581,999	(209,735)	372,264			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,034,975	347,678	3,413,606	5,796,259	(0)	5,796,259	(1,146,193)	4,650,066			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(1,077)	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	(110,939)	30		9
10	Interest and Other Investment Income	(107)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,355)	24		19
20	Contributions	(25,525)	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	(6,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,609)	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	(320,141)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (469,754)		\$	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)	(676,439)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (676,439)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,146,193)		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

ID#

0040071

Report Period Beginning:

01/01/12

Ending:

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Copy Income	\$ (69)	21	1
2	Jury Duty	(52)	10	2
3	Veterans Expense	(45,278)	10	3
4	Patient Needs	(8,036)	10	4
5	Patient Clothing	(403)	10	5
6	Bank Charges	(10,282)	21	6
7	Annual Report	(175)	20	7
8	Alliance for Living- PAC Dues	(12,305)	20	8
9	Non-Allowable Legal Fees	(1,201)	19	9
10	Non-Allowable Administrative Fee	(60,595)	43	10
11	Collection Expense	(6,592)	21	11
12	Building Co: Bank Fees	(1,971)	21	12
13	Building Co: Licenses and Fees	(100)	20	13
14	Building Co: Professional Fees	(10,861)	19	14
15	Building Co: IL Replacement Tax	(4,383)	21	15
16	Building Co: Amortization of Loan Fees	(3,886)	36	16
17	Out of Period Seminar	(368)	24	17
18	Capitalized R&M	(9,389)	06	18
19	Additional R&M	4,945	06	19
20	2011 Bed Tax Assessment	(149,140)	42	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(320,141)		49

ID#

0040071

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

Summary A

12/31/12

[illegible]

Summary B

12/31/12

[illegible]

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,199,630	Monroe Pavilion Associates	100.00%	\$	(1,199,630)	1
2	V	32	Interest	184	Monroe Pavilion Associates	100.00%	304,475	304,291	2
3	V	21	Bank Charges		Monroe Pavilion Associates	100.00%	1,971	1,971	3
4	V	26	Hazard Insurance		Monroe Pavilion Associates	100.00%	5,910	5,910	4
5	V	20	License & Inspection		Monroe Pavilion Associates	100.00%	100	100	5
6	V	19	Professional Fees		Monroe Pavilion Associates	100.00%	10,861	10,861	6
7	V	21	IL Replacement Tax		Monroe Pavilion Associates	100.00%	4,383	4,383	7
8	V	33	Real Estate Taxes		Monroe Pavilion Associates	100.00%	141,989	141,989	8
9	V	30	Depreciation		Monroe Pavilion Associates	100.00%	117,218	117,218	9
10	V	36	Amortization		Monroe Pavilion Associates	100.00%	3,886	3,886	10
11	V	36	MIP Insurance		Monroe Pavilion Associates	100.00%	29,732	29,732	11
12	V								12
13	V								13
14	Total			\$ 1,199,814			\$ 620,525	\$ * (579,289)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 1,508	\$ 1,508	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	3,880	3,880	16
17	V	10	CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	4,756	4,756	17
18	V	17	ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	19,222	19,222	18
19	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	2,073	2,073	19
20	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	269	269	20
21	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	100,721	100,721	21
22	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	70	70	22
23	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	729	729	23
24	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	77	77	24
25	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	24,126	24,126	25
26	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	5,270	5,270	26
27	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	1,010	1,010	27
28	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	4,325	4,325	28
29	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	265	265	29
30	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	3,035	3,035	30
31	V								31
32	V	17	BOOKKEEPING FEES	269,507	NUCARE SERVICES CORP.	100.00%		(269,507)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 269,507			\$ 171,336	\$ * (98,171)	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS / MINOR EQUIPMENT	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 37	\$ 37	15
16	V	10	CLINICAL SALARIES		CLINICAL CONSULTING SERVICES, LLC	100.00%	7,481	7,481	16
17	V	11	ACTIVITY CONSULTANT		CLINICAL CONSULTING SERVICES, LLC	100.00%	302	302	17
18	V	19	PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%			18
19	V	20	DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	52	52	19
20	V	21	OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	12,981	12,981	20
21	V	21	OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	674	674	21
22	V	24	CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	169	169	22
23	V	25	AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	220	220	23
24	V	26	AUTO INSURANCE		CLINICAL CONSULTING SERVICES, LLC	100.00%	59	59	24
25	V	27	PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	901	901	25
26	V	27	OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	(4)	(4)	26
27	V	30	DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	77	77	27
28	V	32	INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	56	56	28
29	V	34	RENT		CLINICAL CONSULTING SERVICES, LLC	100.00%			29
30	V	35	AUTO LEASE		CLINICAL CONSULTING SERVICES, LLC	100.00%	212	212	30
31	V								31
32	V	17	ADMINISTRATIVE FEES	22,195	CLINICAL CONSULTING SERVICES, LLC	100.00%		(22,195)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 22,195			\$ 23,217	\$ * 1,022	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Compensation	\$ 46,365	DIAMOND INSURANCE	100.00%	\$ 46,365	\$	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			\$ 46,365			\$ 46,365	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BARRY AND RANDY CARR	4.750%	CALIFORNIA GARDENS CORP.	CHICAGO	MONROE PAVILION ASSOCIAT	CHICAGO	BUILDING CO.	1
2	FEIGE KNOBEL DISCRETIONARY TRUST	1.583%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REH	CHICAGO	CLINICAL CONSULTING SERV.	LINCOLNWOOD	CLINICAL CONSULTING	2
3	GARY HOKIN	25.000%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	QUEST SERVICES CORP.	LINCOLNWOOD	MARKETING	3
4	GERRY JENICH	5.000%	CLARIDGE IMPERIAL, LTD.	CHICAGO	JLR FINANCIAL SERVICES	LINCOLNWOOD	MANAGEMENT CO.	4
5	MARK HOLLANDER DISCRETIONARY TRUST	1.583%	JACKSON CORP.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	5
6	RAJCHENBACK FAMILY TRUST	4.750%	RENAISSANCE EAST	MESA, ARIZONA	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	6
7	ROBERT HARTMAN	55.750%	RENAISSANCE VILLAGE AL	MESA, ARIZONA	NUCARE SERVICES	LINCOLNWOOD	BOOKKEEPING	7
8	SHARON HOLLANDER DISCRETIONARY TRUST	1.583%	RENAISSANCE VILLAGE IL	MESA, ARIZONA	DIAMOND INSURANCE	LINCOLNWOOD	WORKERS COMP INS	8
9			RENAISSANCE WEST	MESA, ARIZONA	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	9
10			RENAISSANCE PARK SOUTH	CHICAGO	DRAKE LOUIS ENTERPRISE	LINCOLNWOOD	MANAGEMENT CO.	10
11			THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME & MEDICAL SUPPL	11
12			ARIA POST ACUTE CARE	HILLSDALE	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	12
13			THE RENAISSANCE AT MIDWAY, INC.	CHICAGO				13
14			THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO				14
15			CLAREMONT HANOVER PARK	HANOVER PARK				15
16			SEVEN OAKS	GLENDALE, WISC.				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

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

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,228,556	15	\$ 37,226	\$	49,776	\$ 1,508	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,228,556	15	95,768		49,776	3,880	2
3	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,228,556	15	117,394	117,394	49,776	4,756	3
4	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,228,556	15	474,443	462,325	49,776	19,222	4
5	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,228,556	15	51,153		49,776	2,073	5
6	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,228,556	15	6,629		49,776	269	6
7	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,228,556	15	2,485,957	1,190,733	49,776	100,721	7
8	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,228,556	15	1,734		49,776	70	8
9	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,228,556	15	18,004		49,776	729	9
10	26	INSURANCE	AVAIL. CENSUS DAYS	1,228,556	15	1,913		49,776	77	10
11	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,228,556	15	595,462		49,776	24,126	11
12	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,228,556	15	130,061		49,776	5,270	12
13	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,228,556	15	24,917		49,776	1,010	13
14	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,228,556	15	106,750		49,776	4,325	14
15	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,228,556	15	6,532		49,776	265	15
16	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,228,556	15	74,917		49,776	3,035	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,228,859	\$ 1,770,453		\$ 171,336	25

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	REPAIRS / MINOR EQUIPMEN	BED DAYS AVAILABLE	1,228,556	15	\$ 920	\$	49,776	\$ 37	1
2	10	CLINICAL SALARIES	BED DAYS AVAILABLE	1,228,556	15	184,643	184,643	49,776	7,481	2
3	11	ACTIVITY CONSULTANT	BED DAYS AVAILABLE	1,228,556	15	7,452	7,452	49,776	302	3
4	19	PROFESSIONAL FEES	BED DAYS AVAILABLE	1,228,556	15			49,776		4
5	20	DUES, LICENSE & INSPECTION	BED DAYS AVAILABLE	1,228,556	15	1,272		49,776	52	5
6	21	OFFICE WAGES	BED DAYS AVAILABLE	1,228,556	15	320,385	320,385	49,776	12,981	6
7	21	OFFICE EXPENSE	BED DAYS AVAILABLE	1,228,556	15	16,624		49,776	674	7
8	24	CONTINUING EDUCATION / S	BED DAYS AVAILABLE	1,228,556	15	4,175		49,776	169	8
9	25	AUTO EXPENSE	BED DAYS AVAILABLE	1,228,556	15	5,436		49,776	220	9
10	26	AUTO INSURANCE	BED DAYS AVAILABLE	1,228,556	15	1,447		49,776	59	10
11	27	PAYROLL TAXES	BED DAYS AVAILABLE	1,228,556	15	22,241		49,776	901	11
12	27	OTHER EMPLOYEE BENEFITS	BED DAYS AVAILABLE	1,228,556	15	(91)		49,776	(4)	12
13	30	DEPRECIATION	BED DAYS AVAILABLE	1,228,556	15	1,892		49,776	77	13
14	32	INTEREST	BED DAYS AVAILABLE	1,228,556	15	1,384		49,776	56	14
15	34	RENT	BED DAYS AVAILABLE	1,228,556	15			49,776		15
16	35	AUTO LEASE	BED DAYS AVAILABLE	1,228,556	15	5,242		49,776	212	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 573,023	\$ 512,480		\$ 23,217	25

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation			\$	\$		\$ 46,365	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					\$	\$		\$ 46,365	25

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

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

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

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

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

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

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

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

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

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

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

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

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			\$	5,900,522			\$	304,475	1	
2													2	
3													3	
4													4	
5	See Supplemental Schedule												5	
	Working Capital													
6	Bank of America		X	Line of Credit	Interest Only							18,650	6	
7	Bank of America		X	Line of Credit								11,852	7	
8	See Supplemental Schedule											1,066	8	
9	TOTAL Facility Related						\$	5,900,522				\$	336,043	9
	B. Non-Facility Related*													
10	Interest Income (Bldg Co.)		X									(184)	10	
11	Interest Income		X									(107)	11	
12													12	
13	See Supplemental Schedule												13	
14	TOTAL Non-Facility Related						\$					\$	(291)	14
15	TOTALS (line 9+line14)						\$	5,900,522				\$	335,752	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 29,732 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Allocated from Nucare		X				\$	\$			\$ 1,010	8	
9	Allocated from Clinical Consulting		X								56	9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										1,066	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.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	148,992	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.)		\$	148,375	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(617)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	146,931	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.		\$	67	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.		\$	146,382	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	165,300	8	
		2008	166,959	9	
		2009	167,519	10	
		2010	144,652	11	
		2011	144,050	12	
2012 Accrual=\$144,050 X 1.02 = \$146,931					
Allocated from Nucare: \$4,325					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Monroe Pavilion Health Ctr. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040071

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>17-17-102-043-0000</u>	<u>Long Term Care Property</u>	\$ <u>144,050.35</u>	\$ <u>144,050.35</u>
2. <u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>84,353.24</u>	\$ <u>3,075.88</u>
3. <u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>84,353.24</u>	\$ <u>170.88</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>312,756.83</u></u>	\$ <u><u>147,297.11</u></u>

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Monroe Pavilion Health Ctr.

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0040071

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE

FAX #:

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	39,159	1982	\$ 30,464	1
2	Allocated from 7257 N Lincoln Ave			6,158	2
3	TOTALS	39,159		\$ 36,622	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pavilion Health Ctr.

0040071

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	136			1978	\$ 2,116,772	\$ 117,218	26	\$	\$ (117,218)	\$ 2,059,134	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1986	32,967		20				9	
10	Various			1987	4,735		20				10	
11	Various			1988	8,738		20				11	
12	Various			1989	11,001		20				12	
13	Various			1990	1,919		20				13	
14	Various			1991	5,128		20				14	
15	Various			1992	4,600		20				15	
16	Various			1993	17,616		20				16	
17	Various			1994	13,951		20	358	358	6,545	17	
18	Various			1995	13,124		20	656	656	11,592	18	
19	Various			1996	19,194		20	960	960	15,540	19	
20	Various			1997	32,365		20	1,618	1,618	25,115	20	
21	Various			1998	50,879		20	2,544	2,544	36,513	21	
22	Various			1999	63,549		20	3,177	3,177	43,394	22	
23	Various			2000	62,515		20	3,126	3,126	39,747	23	
24	Various			2001	42,063		20	2,103	2,103	24,407	24	
25	Various			2002	32,776		20	1,648	1,648	19,449	25	
26	Various			2003	195,702		20	4,187	4,187	190,900	26	
27	Various			2004	5,054		20	372	372	3,266	27	
28	Various			2005	4,804		20	445	445	3,222	28	
29	Various			2006	143,838		20	9,048	9,048	61,533	29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

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

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	36,719			1,835	1,835	16,072	67
68	Related Party Allocations (Pages 12H & 12I)	89,247	3,037		3,347	310	25,005	68
69	Financial Statement Depreciation		44,467			(44,467)		69
70	TOTAL (lines 4 thru 69)	\$ 3,009,256	\$ 164,722		\$ 35,424	\$ (129,298)	\$ 2,581,433	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

0040071

Report Period Beginning:

01/01/12

Ending:

12/31/12

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		\$ 3,009,256	\$ 164,722		\$ 35,424	\$ (129,298)	\$ 2,581,433	1
2	Concrete Drain	2009	4,500		20	450	450	1,725	2
3	Concrete Wall	2009	3,532		20	236	236	824	3
4	Paint 16 Rooms, Door Frames, 1 Tv Room, 2 Bathrooms On 1St &	2011	4,125		20	413	413	653	4
5	Paint 16 Rooms, Door Frames, 1 Tv Room, 2 Bathrooms On 3Rd F	2011	3,700		20	370	370	586	5
6	Paint 16 Rooms, Door Frames, 1 Tv Room, 2 Bathrooms On 4Th F	2011	3,700		20	370	370	555	6
7	Demolish And Rebuild Shower Room, Install New Green Drywall,	2011	3,200		20	320	320	480	7
8	Paint Walls, Doorframes, Doors, Ceilings In Corridors On 1St, 2N	2011	19,420		20	1,942	1,942	2,751	8
9	Shower & Toilet Rms-Lighting,Finish Walls, Fixtures;Relaminate	2012	44,420		20	2,961	2,961	2,961	9
10	104 Pcs. Hand Rails For Stair Case	2012	3,500		20	58	58	58	10
11	Elevator Repair	2012	3,469		20	173	173	173	11
12	Boiler Repair	2012	5,920		20	296	296	296	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)		\$ 3,108,742	\$ 164,722		\$ 43,014	\$ (121,708)	\$ 2,592,497	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,108,742	\$ 164,722		\$ 43,014	\$ (121,708)	\$ 2,592,497	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)		\$ 3,108,742	\$ 164,722		\$ 43,014	\$ (121,708)	\$ 2,592,497	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 3,108,742	\$ 164,722		\$ 43,014	\$ (121,708)	\$ 2,592,497	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)		\$ 3,108,742	\$ 164,722		\$ 43,014	\$ (121,708)	\$ 2,592,497	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,108,742	\$ 164,722		\$ 43,014	\$ (121,708)	\$ 2,592,497	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)		\$ 3,108,742	\$ 164,722		\$ 43,014	\$ (121,708)	\$ 2,592,497	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2004	5,493		20	275	275	3,655	9
10	Various	2005	11,502		20	574	574	7,487	10
11	Drapery Panel; Curtains	2007	19,724		20	986	986	4,930	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									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	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		\$ 36,719	\$		\$ 1,835	\$ 1,835	\$ 16,072	34
TOTAL (12F & 12G lines 1 thru 33)								

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

0040071

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Avenue	2004	52,509	1,346	35	1,500	154	13,690	3
4	Allocated from Clinical Consulting Services	2004	2,917	75	35	83	8	761	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 7257 N. Lincoln Avenue	2005	4,787	34	20	309	275	2,258	9
10	Allocated from 7257 N. Lincoln Avenue	2004	1,043		20	52	52	444	10
11									11
12	Allocated from Clinical Consulting Services	2005	266	2	20	17	15	125	12
13	Allocated from Clinical Consulting Services	2004	58		20	3	3	25	13
14									14
15	Allocated from NuCare Services	2003	475	27	20	24	(3)	216	15
16	Allocated from NuCare Services	2004	9,635	550	20	482	(68)	4,201	16
17	Allocated from NuCare Services	2005	571	33	20	29	(4)	224	17
18	Allocated from NuCare Services	2006	775	44	20	39	(5)	246	18
19	Allocated from NuCare Services	2008	816	47	20	41	(6)	174	19
20	Allocated from NuCare Services	2009	13,144	751	20	657	(94)	2,373	20
21	Allocated from NuCare Services	2010	2,020	115	20	101	(14)	253	21
22	Allocated from NuCare Services	2011	109	6	20	5	(1)	10	22
23	Allocated from NuCare Services	2012	122	7	20	5	(2)	5	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 89,247	\$ 3,037		\$ 3,347	\$ 310	\$ 25,005	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$270,850	\$1,902	\$12,177	\$10,275	10	\$176,656	71
72	Current Year Purchases	9,694	387	826	439	10	826	72
73	Fully Depreciated Assets	178,399		4	4	10	178,398	73
74								74
75	TOTALS	\$458,943	\$2,289	\$13,007	\$10,718		\$355,880	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1991 FORD E150	1994	\$2,200	\$	\$		5	\$	76
77		Allocated from Nuicare	2012	359	20	72	52	5	173	77
78										78
79										79
80	TOTALS			\$2,559	\$20	\$72	\$52		\$173	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$3,606,866	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$167,031	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$56,092	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(110,939)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,948,550	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Nucare				265			5
6								6
7	TOTAL				\$265			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:
- *

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: \$13,837
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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	N/A	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 46,519	\$ 270,500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,101,179	1,123,776	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,343	90,202	6
7	Other Prepaid Expenses	3,252	3,252	7
8	Accounts Receivable (owners or related parties)	153,471	153,471	8
9	Other(specify): See Attached Schedule	2,610,732	2,874,292	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,978,496	\$ 4,515,493	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	777,479	3,167,709	15
16	Equipment, at Historical Cost	414,548	668,882	16
17	Accumulated Depreciation (book methods)	(947,913)	(3,795,120)	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		103,958	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 244,114	\$ 2,699,465	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,222,610	\$ 7,214,958	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 753,921	\$ 753,922	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,141	14,141	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	188,232	188,232	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,412	10,412	31
32	Accrued Real Estate Taxes(Sch.IX-B)		146,931	32
33	Accrued Interest Payable		25,176	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,465	8,465	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,925,680	2,934,201	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,900,851	\$ 4,081,480	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,900,522	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,900,522	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,900,851	\$ 9,982,002	46
47	TOTAL EQUITY(page 18, line 24)	\$ 321,759	\$ (2,767,044)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,222,610	\$ 7,214,958	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 260,235	1
2	Restatements (describe):		2
3	Hazard Restatement	(13,416)	3
4	Rounding	5	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 246,824	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	74,935	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)	\$ 74,935	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)	\$ 321,759	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,866,113	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,866,113	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions	10	24
25	Interest and Other Investment Income***	107	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 117	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	4,964	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,964	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,871,194	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	863,568	31
32	Health Care	1,795,020	32
33	General Administration	1,270,483	33
	B. Capital Expense		
34	Ownership	1,285,189	34
	C. Ancillary Expense		
35	Special Cost Centers	60,595	35
36	Provider Participation Fee	521,404	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,796,259	40
41	Income before Income Taxes (line 30 minus line 40)**	74,935	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 74,935	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,434,202	44
45	Private Pay - Net Inpatient Revenue	4,980	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Veterans	426,931	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,866,113	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.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,971	2,091	\$ 84,381	\$ 40.35	1
2	Assistant Director of Nursing	995	1,154	36,741	31.84	2
3	Registered Nurses	4,682	5,124	144,572	28.21	3
4	Licensed Practical Nurses	23,475	25,631	581,891	22.70	4
5	CNAs & Orderlies	43,072	48,841	534,745	10.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,975	2,171	33,845	15.59	9
10	Activity Assistants	5,353	5,950	59,823	10.05	10
11	Social Service Workers	2,488	2,914	67,964	23.32	11
12	Dietician	1,860	2,067	49,245	23.82	12
13	Food Service Supervisor					13
14	Head Cook	4,176	4,656	45,213	9.71	14
15	Cook Helpers/Assistants	9,424	10,365	106,826	10.31	15
16	Dishwashers					16
17	Maintenance Workers	2,825	3,140	41,897	13.34	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,506	1,794	69,495	38.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,970	2,197	64,791	29.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,296	4,820	70,812	14.69	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,237	2,405	42,734	17.77	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	112,305	125,320	\$ 2,034,975 *	\$ 16.24	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	144	\$ 6,968	01-03	35
36	Medical Director	Monthly	27,000	09-03	36
37	Medical Records Consultant	Monthly	394	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,265	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	25	1,504	11-03	44
45	Social Service Consultant	30	1,785	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	199	\$ 43,916		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Wayne Hanik	Administrator	0.00%	\$ 23,511	Workers' Compensation Insurance	\$	46,365	IDPH License Fee	\$ 1,492
Linda Williams	Administrator	0.00%	45,985	Unemployment Compensation Insurance		34,716	Advertising: Employee Recruitment	665
				FICA Taxes		155,676	Health Care Worker Background Check	
				Employee Health Insurance		105,925	(Indicate # of checks performed 242)	2,903
				Employee Meals		9,662	Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Dues and Subscriptions	2,485
				City of Chicago Taxes		1,647	Licenses & Inspections	2,258
				401(K) Matching Expense		1,914	Advertising & Promotion	3,609
				Vision Insurance		116	Allocated from Nucare	269
				Other Employee Benefits		8,617	See Supplemental Schedule	52
							Less: Public Relations Expense	()
							Non-allowable advertising	(3,609)
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)								
			\$ 69,495					
B. Administrative - Other								
	Description		Amount					
	NuCare Services Corp - Bookkeeping Fees		\$ 269,507					
	Clinical Consulting-Administrative Fees		22,195					
TOTAL (agree to Schedule V, line 17, col. 3)								
(Attach a copy of any management service agreement)								
			\$ 291,702					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg, & Rothblatt	Accounting		\$ 20,876			\$	Out-of-State Travel	\$
PSD Solutions	Strategic Development		2,110					
MEDIFAX-EDI, LLC	Computer Services		37					
HDSI	Computer Services		6,104				In-State Travel	
MDI Achieve	Computer Services		18,933					
Personnel Planners	Unemployment Consulting		945					
See Attached	Legal		17,885					
CDW Computer Centers	Computer Services		260					
CES Consulting of IL LLC	Cost Effective Solutions		71				Seminar Expense	2,288
MTS Consulting Inc	Enterprize Zone		62				Allocated from Nucare	70
							Allocated from Clinical Consult Svc	169
							Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	\$ 2,527
			\$ 67,284					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 \$12,556

(3) Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 Years

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

\$ 123

Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

X

YES

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES X

NO

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 372,264

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

N/A

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 9,662

Has any meal income been offset against related costs?

No

Indicate the amount. \$ N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100% Ln 14

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name: N/A

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

Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT