

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	<u>136</u>	Intermediate (ICF)	<u>136</u>	<u>49,640</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>136</u>	TOTALS	<u>136</u>	<u>49,640</u>	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					10
11	ICF/DD	<u>43,336</u>		<u>4,181</u>	<u>47,517</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,336</u>		<u>4,181</u>	<u>47,517</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.72%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 07/01/1994

J. Was the facility purchased or leased after January 1, 1978?

YES Date 07/01/1994 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO 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: 12/31/13 Fiscal Year: 12/13/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	206,406	17,397	6,868	230,671		230,671		230,671		1
2	Food Purchase		201,934		201,934	(10,760)	191,174		191,174		2
3	Housekeeping		2,213	117,677	119,890		119,890		119,890		3
4	Laundry		6,449	77,290	83,739		83,739		83,739		4
5	Heat and Other Utilities			137,833	137,833		137,833	396	138,229		5
6	Maintenance	42,971	22,079	75,933	140,983		140,983	10,845	151,828		6
7	Other (specify):*										7
8	TOTAL General Services	249,377	250,072	415,601	915,050	(10,760)	904,290	11,241	915,531		8
	B. Health Care and Programs										
9	Medical Director			27,000	27,000		27,000		27,000		9
10	Nursing and Medical Records	1,487,686	112,886	9,189	1,609,761		1,609,761	(68,315)	1,541,446		10
10a	Therapy										10a
11	Activities	99,289	9,865	2,137	111,291		111,291	571	111,862		11
12	Social Services	141,509		2,490	143,999		143,999		143,999		12
13	CNA Training										13
14	Program Transportation			3,100	3,100		3,100		3,100		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,728,484	122,751	43,916	1,895,151		1,895,151	(67,744)	1,827,407		16
	C. General Administration										
17	Administrative	103,104		324,324	427,428		427,428	(300,700)	126,728		17
18	Directors Fees										18
19	Professional Services			138,521	138,521	(15,398)	123,123	(47,142)	75,981		19
20	Dues, Fees, Subscriptions & Promotions			49,318	49,318		49,318	(41,599)	7,719		20
21	Clerical & General Office Expenses	46,347	12,261	61,693	120,301		120,301	112,333	232,634		21
22	Employee Benefits & Payroll Taxes			386,837	386,837	10,760	397,597		397,597		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,470	2,470		2,470	288	2,758		24
25	Other Admin. Staff Transportation							1,165	1,165		25
26	Insurance-Prop.Liab.Malpractice			132,163	132,163		132,163	8,266	140,429		26
27	Other (specify):*							29,398	29,398		27
28	TOTAL General Administration	149,451	12,261	1,095,326	1,257,038	(4,638)	1,252,400	(237,991)	1,014,409		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,127,312	385,084	1,554,843	4,067,239	(15,398)	4,051,841	(294,495)	3,757,347		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 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	
	D. Ownership											
30	Depreciation			45,779	45,779		45,779	14,033	59,812			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,837	35,837		35,837	299,630	335,467			32
33	Real Estate Taxes					15,398	15,398	218,675	234,072			33
34	Rent-Facility & Grounds			765,564	765,564		765,564	(765,290)	274			34
35	Rent-Equipment & Vehicles			14,506	14,506		14,506	3,572	18,078			35
36	Other (specify):*							29,307	29,307			36
37	TOTAL Ownership			861,686	861,686	15,398	877,084	(200,073)	677,010			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			272,787	272,787		272,787		272,787			42
43	Other (specify):*	20,593			20,593		20,593	(20,593)				43
44	TOTAL Special Cost Centers	20,593		272,787	293,380		293,380	(20,593)	272,787			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,147,905	385,084	2,689,316	5,222,305		5,222,305	(515,161)	4,707,144			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning: 01/01/13

Ending: 12/31/13

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(1,135)	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	(111,164)	30		9
10	Interest and Other Investment Income	(434)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(29)	21		18
19	Entertainment	(324)	24		19
20	Contributions	(19,850)	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	(12,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,754)	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	(195,469)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (344,160)		\$	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	2	
		Amount	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)	(171,001)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (171,001)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (515,161)		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	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Monroe Pav Hlth Treatmnt CtrID# 0040071Report Period Beginning: 01/01/13Ending: 12/31/13

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc. Income - Record Copies	\$ (10)	21	1
2	Jury Duty Income	(17)	10	2
3	Patient Needs	(8,263)	10	3
4	Patient Clothing	(952)	10	4
5	Veterans Expense	(62,704)	10	5
6	Bank Charges	(15,213)	21	6
7	Office - Outside Labor	(4,376)	21	7
8	Building Co: Bank Fees	(859)	21	8
9	Building Co: Licenses and Fees	(100)	20	9
10	Building Co: Professional Fees	(10,830)	19	10
11	Building Co: IL Replacement Tax	(3,574)	21	11
12	Building Co: Amortization of Loan Fees	(3,886)	36	12
13	Alliance for Living- PAC Dues	(18,811)	20	13
14	Annual Report	(175)	20	14
15	Additional R&M	6,640	06	15
16	Non-allowable Legal Fees	(51,746)	19	16
17	Marketing Salries	(20,593)	43	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(195,469)	49

Monroe Pav Hlth Treatmnt Ctr

ID# 0040071

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr# 0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(1,135)		1,531									396	5
6	Maintenance	6,640		4,205									10,845	6
7	Other (specify):*													7
8	TOTAL General Services	5,505		5,736									11,241	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(71,936)		3,771			(150)						(68,315)	10
10a	Therapy													10a
11	Activities			571									571	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(71,936)		4,342			(150)						(67,744)	16
	C. General Administration													
17	Administrative			(300,700)									(300,700)	17
18	Directors Fees													18
19	Professional Services	(62,576)	10,830	4,604									(47,142)	19
20	Fees, Subscriptions & Promotions	(42,690)	100	991									(41,599)	20
21	Clerical & General Office Expenses	(36,061)	4,433	143,961									112,333	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(324)		612									288	24
25	Other Admin. Staff Transportation			1,165									1,165	25
26	Insurance-Prop.Liab.Malpractice		7,251	1,015									8,266	26
27	Other (specify):*			29,398									29,398	27
28	TOTAL General Administration	(141,651)	22,614	(118,954)									(237,991)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(208,082)	22,614	(108,876)			(150)						(294,495)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(111,164)	116,724	8,473									14,033	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(434)	299,004	1,060									299,630	32
33	Real Estate Taxes		214,874	3,801									218,675	33
34	Rent-Facility & Grounds		(765,564)	274									(765,290)	34
35	Rent-Equipment & Vehicles			3,572									3,572	35
36	Other (specify):*	(3,886)	33,193										29,307	36
37	TOTAL Ownership	(115,484)	(101,769)	17,180									(200,073)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(20,593)											(20,593)	43
44	TOTAL Special Cost Centers	(20,593)											(20,593)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(344,160)	(79,155)	(91,696)			(150)						(515,161)	45

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	\$ 765,564	Monroe Pavilion Associates	100.00%	\$	\$ (765,564)	1
2	V	32 Interest	206	Monroe Pavilion Associates	100.00%	299,210	299,004	2
3	V	21 Bank Charges		Monroe Pavilion Associates	100.00%	859	859	3
4	V	26 Hazard Insurance		Monroe Pavilion Associates	100.00%	7,251	7,251	4
5	V	20 License & Inspection		Monroe Pavilion Associates	100.00%	100	100	5
6	V	19 Professional Fees		Monroe Pavilion Associates	100.00%	10,830	10,830	6
7	V	21 IL Replacement Tax		Monroe Pavilion Associates	100.00%	3,574	3,574	7
8	V	33 Real Estate Taxes		Monroe Pavilion Associates	100.00%	214,874	214,874	8
9	V	30 Depreciation		Monroe Pavilion Associates	100.00%	116,724	116,724	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%	29,307	29,307	11
12	V							12
13	V							13
14	Total		\$ 765,770			\$ 686,615	\$ * (79,155)	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%	\$ 1,531	\$ 1,531
16	V	6 MAINTENANCE SALARIES		NUCARE SERVICES CORP.	100.00%	519	519
17	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	3,686	3,686
18	V	10 CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	3,771	3,771
19	V	11 ACTIVITY SALARIES		NUCARE SERVICES CORP.	100.00%	571	571
20	V	17 ADMINISTRATIVE SALARIES - NON-OWNER		NUCARE SERVICES CORP.	100.00%	23,624	23,624
21	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	4,604	4,604
22	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	991	991
23	V	21 CLERICAL & GENERAL SALARIES		NUCARE SERVICES CORP.	100.00%	129,208	129,208
24	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	14,752	14,752
25	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	612	612
26	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	1,165	1,165
27	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	1,015	1,015
28	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	29,398	29,398
29	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	8,473	8,473
30	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	1,060	1,060
31	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	3,801	3,801
32	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	274	274
33	V	35 AUTO LEASE		NUCARE SERVICES CORP.	100.00%	2,200	2,200
34	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	1,372	1,372
35	V						
36	V	17 BOOKKEEPING FEES	324,324	NUCARE SERVICES CORP.	100.00%		(324,324)
37	V						
38	V						
39	Total		\$ 324,324			\$ 232,628	\$ * (91,696)

* 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	\$ 18,858	DIAMOND INSURANCE		\$ 18,858	\$	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		\$ 18,858			\$ 18,858	\$ *	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	\$ 49,394	MAPLE LEAF	100.00%	\$ 49,394	\$	15
16	V	26 Liability Insurance	125,159	MAPLE LEAF	100.00%	125,159		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		\$ 174,553			\$ 174,553	\$ *	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	10 DME and Medical Supplies	\$ 3,409	Integra Healthcare Equipment		\$ 3,259	\$ (150)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 3,409			\$ 3,259	\$ * (150)

* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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

* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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

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 & REI	CHICAGO	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY INS	2
3	GARY HOKIN	25.000%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	JLR FINANCIAL SERVICES	LINCOLNWOOD	MANAGEMENT CO.	3
4	GERRY JENICH	5.000%	CLARIDGE IMPERIAL, LTD.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	4
5	MARK HOLLANDER DISCRETIONARY TRUST	1.583%	JACKSON CORP.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	5
6	RAJCHENBACK FAMILY TRUST	4.750%	RENAISSANCE EAST	MESA, ARIZONA	NUCARE SERVICES	LINCOLNWOOD	BOOKKEEPING	6
7	ROBERT HARTMAN	55.750%	RENAISSANCE VILLAGE AL	MESA, ARIZONA	DIAMOND INSURANCE	LINCOLNWOOD	WORKERS COMP INS	7
8	SHARON HOLLANDER DISCRETIONARY TRUST	1.583%	RENAISSANCE VILLAGE IL	MESA, ARIZONA	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	8
9			RENAISSANCE WEST	MESA, ARIZONA	DRAKE LOUIS ENTERPRISE	LINCOLNWOOD	MANAGEMENT CO.	9
10			RENAISSANCE PARK SOUTH	CHICAGO	INTEGRA HEALTHCARE EQUI	ELMHURST	DME & MEDICAL SUPPL	10
11			THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	11
12			ARIA POST ACUTE CARE	HILLSIDE				12
13			THE RENAISSANCE AT MIDWAY, INC.	CHICAGO				13
14			THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO				14
15			CLAREMONT HANOVER PARK	HANOVER PARK				15
16			SEVEN OAKS	GLENDALE, WISC.				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts									11
12	anticipated to be considered allowable by the IL. Dept. of HFS.									12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

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	5	UTILITIES	AVAIL. CENSUS DAYS 1,205,960	16	\$ 37,199	\$	49,640	\$ 1,531	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS 1,205,960	16	12,620	12,620	49,640	519	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS 1,205,960	16	89,537		49,640	3,686	3
4	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS 1,205,960	16	91,606	91,606	49,640	3,771	4
5	11	ACTIVITY SALARIES	AVAIL. CENSUS DAYS 1,205,960	16	13,872	13,872	49,640	571	5
6	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS 1,205,960	16	573,931	573,931	49,640	23,624	6
7	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 1,205,960	16	111,853		49,640	4,604	7
8	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS 1,205,960	16	24,065		49,640	991	8
9	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS 1,205,960	16	3,139,005	3,139,005	49,640	129,208	9
10	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS 1,205,960	16	358,395		49,640	14,752	10
11	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS 1,205,960	16	14,876		49,640	612	11
12	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS 1,205,960	16	28,298		49,640	1,165	12
13	26	INSURANCE	AVAIL. CENSUS DAYS 1,205,960	16	24,669		49,640	1,015	13
14	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS 1,205,960	16	714,188		49,640	29,398	14
15	30	DEPRECIATION	AVAIL. CENSUS DAYS 1,205,960	16	205,852		49,640	8,473	15
16	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS 1,205,960	16	25,740		49,640	1,060	16
17	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS 1,205,960	16	92,330		49,640	3,801	17
18	34	PARKING LOT RENT	AVAIL. CENSUS DAYS 1,205,960	16	6,664		49,640	274	18
19	35	AUTO LEASE	AVAIL. CENSUS DAYS 1,205,960	16	53,447		49,640	2,200	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS 1,205,960	16	33,335		49,640	1,372	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,651,481	\$ 3,831,033		\$ 232,628	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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 ()

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

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	22	Workers Compensation	Direct Allocation		\$	\$		\$ 18,858	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				\$	\$		\$ 18,858	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

Name of Related Organization Maple Leaf Insurance
 Street Address PO Box 69,720 West Bay Rd.
 City / State / Zip Code Grand Cayman KY1-1102
 Phone Number ()
 Fax Number ()

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

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	22	Workers Compensation	Direct Allocation		\$	\$		\$ 49,394	1
2	26	Libility Insurance	Direct Allocation					125,159	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				\$	\$		\$ 174,553	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

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	10	DME & Medical Supplies	Direct Cost		\$	\$		\$ 3,259	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				\$	\$		\$ 3,259	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Name of Lender	2		3	4	5	6		8	9	10						
		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			\$	\$ 5,795,286			\$ 299,210	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6	Private Bank		X	Line of Credit	Interest Only						4,199	6					
7	Private Bank		X	Line of Credit				746,857			31,638	7					
8	See Supplemental Schedule										1,060	8					
9	TOTAL Facility Related						\$	\$ 6,542,143			\$ 336,107	9					
B. Non-Facility Related*																	
10	Interest Income (Bldg Co.)		X								(206)	10					
11	Interest Income		X								(434)	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (640)	14					
15	TOTALS (line 9+line14)						\$	\$ 6,542,143			\$ 335,467	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 29,307 Line # 36

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number

Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8	Allocated from Nucare		X				\$	\$			\$ 377					
9	Alloc. From 7257 N. Lincoln		X								683					
10																
11																
12																
13																
14	TOTAL Working Capital										1,060					
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 2012 report.		\$	<u>146,931</u>		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.)		\$	<u>180,291</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>33,360</u>		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>185,315</u>		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.)		\$	<u>15,398</u>		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.		\$	<u>234,073</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>166,959</u>	8	FOR BHF USE ONLY	
	2009	<u>167,519</u>	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$ 13
	2010	<u>144,652</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2011	<u>144,050</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2012	<u>176,490</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>2013 Accrual=\$176,490 X 1.05 = \$185,315</u>					
<u>Allocated from Nuicare: \$3,801</u>					

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Monroe Pav Hlth Treatmnt Ctr COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0040071
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-17-102-043-0000</u>	<u>Long Term Care Property</u>	\$ <u>176,490.14</u>	\$ <u>176,490.14</u>
2. <u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>88,815.89</u>	\$ <u>3,655.86</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>265,306.03</u></u>	\$ <u><u>180,146.00</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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071 Report Period Beginning:

01/01/13 Ending:

12/31/13

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	<u>Facility</u>	<u>39,159</u>	<u>1982</u>	<u>\$ 30,464</u>	1
2	<u>Allocated from 7257 N Lincoln Ave</u>			<u>6,586</u>	2
3	TOTALS	39,159		\$ 37,050	3

SEE ACCOUNTANTS' COMPILATION REPORT

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			36,719		1,835	1,835	17,907	67	
68			93,962	4,263	3,501	(762)	29,830	68	
69				45,779		(45,779)		69	
70			\$ 3,022,003	\$ 166,766		\$ 33,431	\$ (133,335)	\$ 2,676,376	70

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	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	\$ 116,724	26	\$	\$ (116,724)	\$ 2,116,772	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	6,903	17
18	Various		1995	13,124		20	656	656	12,248	18
19	Various		1996	19,194		20	960	960	16,499	19
20	Various		1997	32,365		20	1,618	1,618	26,733	20
21	Various		1998	50,879		20	2,544	2,544	39,057	21
22	Various		1999	63,549		20	3,177	3,177	46,571	22
23	Various		2000	62,515		20	3,126	3,126	42,873	23
24	Various		2001	42,063		20	2,103	2,103	26,510	24
25	Various		2002	32,776		20	1,164	1,164	20,612	25
26	Various		2003	195,702		20	1,838	1,838	192,738	26
27	Various		2004	5,054		20	372	372	3,638	27
28	Various		2005	4,804		20	445	445	3,667	28
29	Various		2006	143,838		20	9,048	9,048	70,582	29
30	Various		2009	8,032		20	686	686	3,235	30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,022,003	\$ 166,766		\$ 33,431	\$ (133,335)	\$ 2,676,376	1
2	Paint 16 Rooms, Door Frames, 1 Tv Room, 2 Bathrooms On 1St &	2011	4,125		20	413	413	1,066	2
3	Paint 16 Rooms, Door Frames, 1 Tv Room, 2 Bathrooms On 3Rd F	2011	3,700		20	370	370	956	3
4	Paint 16 Rooms, Door Frames, 1 Tv Room, 2 Bathrooms On 4Th F	2011	3,700		20	370	370	925	4
5	Demolish And Rebuild Shower Room, Install New Green Drywall,	2011	3,200		20	320	320	800	5
6	Paint Walls, Doorframes, Doors, Ceilings In Corridors On 1St, 2Nd	2011	19,420		20	1,942	1,942	4,693	6
7	Renovation 8 Common Bathrooms	2012	44,420		20	4,442	4,442	7,403	7
8	104 Pcs. Hand Rails For Stair Case	2012	3,500		20	350	350	408	8
9	Elevator Repair	2012	3,469		20	173	173	346	9
10	Boiler Repair	2012	5,920		20	296	296	592	10
11	Fire Pump Package	2013	49,072		20	3,680	3,680	3,680	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)		\$ 3,162,529	\$ 166,766		\$ 45,787	\$ (120,979)	\$ 2,697,245	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward								
2		\$ 3,162,529	\$ 166,766		\$ 45,787	\$ (120,979)	\$ 2,697,245		1
3									2
4									3
5									4
6									5
7									6
8									7
9									8
10									9
11									10
12									11
13									12
14									13
15									14
16									15
17									16
18									17
19									18
20									19
21									20
22									21
23									22
24									23
25									24
26									25
27									26
28									27
29									28
30									29
31									30
32									31
33									32
34	TOTAL (lines 1 thru 33)	\$ 3,162,529	\$ 166,766		\$ 45,787	\$ (120,979)	\$ 2,697,245		33
									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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		\$ 3,162,529	\$ 166,766		\$ 45,787	\$ (120,979)	\$ 2,697,245	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)		\$ 3,162,529	\$ 166,766		\$ 45,787	\$ (120,979)	\$ 2,697,245	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,162,529	\$ 166,766		\$ 45,787	\$ (120,979)	\$ 2,697,245	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)		\$ 3,162,529	\$ 166,766		\$ 45,787	\$ (120,979)	\$ 2,697,245	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	3,930	9
10	Various	2005	11,502		20	574	574	8,061	10
11	Drapery Panel; Curtains	2007	19,724		20	986	986	5,916	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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 36,719	\$		\$ 1,835	\$ 1,835	\$ 17,907	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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Avenue	2004	59,274	1,520	20	1,694	174	17,147	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from NuCare Services	2003	482	46	20	24	(22)	244	9
10	Allocated from NuCare Services	2004	9,789	942	20	490	(452)	4,758	10
11	Allocated from NuCare Services	2005	580	56	20	29	(27)	257	11
12	Allocated from NuCare Services	2006	787	76	20	39	(37)	290	12
13	Allocated from NuCare Services	2008	829	80	20	41	(39)	218	13
14	Allocated from NuCare Services	2009	13,354	1,285	20	668	(617)	3,078	14
15	Allocated from NuCare Services	2010	2,052	197	20	103	(94)	360	15
16	Allocated from NuCare Services	2011	111	11	20	6	(5)	16	16
17	Allocated from NuCare Services	2012	123	12	20	6	(6)	11	17
18									18
19	Allocated from 7257 N. Lincoln Avenue	2005	5,403	38	20	342	304	2,891	19
20	Allocated from 7257 N. Lincoln Avenue	2004	1,178		20	59	59	560	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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		\$ 93,962	\$ 4,263		\$ 3,501	\$ (762)	\$ 29,830	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	\$ 276,737	\$ 3,913	\$ 11,619	\$ 7,706	10	\$ 185,068	71
72	Current Year Purchases	23,978	263	2,331	2,068	10	2,331	72
73	Fully Depreciated Assets	183,081		3	3	10	183,081	73
74								74
75	TOTALS	\$ 483,796	\$ 4,176	\$ 13,953	\$ 9,777		\$ 370,479	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1991 FORD E150	1994	\$ 2,200	\$	\$	\$	5	\$	76
77		Allocated from Nucare	2013	365	35	73	38	5	249	77
78										78
79										79
80	TOTALS			\$ 2,565	\$ 35	\$ 73	\$ 38		\$ 249	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,685,940	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 170,977	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 59,813	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (111,164)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,067,973	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	<u>Allocated from Nuicare</u>				<u>274</u>			5
6								6
7	TOTAL				\$ 274			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 15,878 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	<u>Allocated from Nuicare</u>		\$	\$ <u>2,200</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 2,200	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr # 0040071 Report Period Beginning: 01/01/13 Ending: 12/31/13
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)		Total Units (Column 2 + 4)		Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist		hrs	\$		\$		\$								1
2	Licensed Speech and Language Development Therapist	N/A	hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													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

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

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	\$ 41,920	\$ 250,765	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	902,897	925,494	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,056	29,382	6
7	Other Prepaid Expenses	4,067	4,067	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		301,303	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 950,940	\$ 1,511,011	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	830,778	3,221,008	15
16	Equipment, at Historical Cost	438,208	692,542	16
17	Accumulated Depreciation (book methods)	(993,692)	(3,957,623)	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): <u>See Attached Schedule</u>	330,210	430,282	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 605,504	\$ 2,940,245	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,556,444	\$ 4,451,256	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 261,699	\$ 261,698	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,590	7,590	28
29	Short-Term Notes Payable	746,857	746,857	29
30	Accrued Salaries Payable	188,206	188,206	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,584	12,584	31
32	Accrued Real Estate Taxes(Sch.IX-B)		185,315	32
33	Accrued Interest Payable		24,726	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,465	8,465	35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,225,401	\$ 1,435,441	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,795,286	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>	17,772	8,521	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 17,772	\$ 5,803,807	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,243,173	\$ 7,239,248	46
47	TOTAL EQUITY(page 18, line 24)	\$ 313,271	\$ (2,787,992)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,556,444	\$ 4,451,256	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 321,759	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 321,760	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(8,489)	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)	\$ (8,489)	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)	\$ 313,271	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	\$ 5,213,355	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,213,355	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	434	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 434	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	27	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,213,816	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	915,050	31
32	Health Care	1,895,151	32
33	General Administration	1,257,038	33
B. Capital Expense			
34	Ownership	861,686	34
C. Ancillary Expense			
35	Special Cost Centers	20,593	35
36	Provider Participation Fee	272,787	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,222,305	40
41	Income before Income Taxes (line 30 minus line 40)**	(8,489)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (8,489)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,664,242	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Veteran</u>	549,113	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,213,355	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	1,463	1,858	\$ 72,629	\$ 39.09	1
2	Assistant Director of Nursing	1,965	2,078	69,706	33.54	2
3	Registered Nurses	3,670	3,969	124,707	31.42	3
4	Licensed Practical Nurses	25,063	27,002	654,884	24.25	4
5	CNAs & Orderlies	43,451	47,654	527,761	11.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,109	2,246	36,973	16.46	9
10	Activity Assistants	5,611	6,072	62,316	10.26	10
11	Social Service Workers	5,908	6,374	141,509	22.20	11
12	Dietician	1,866	2,074	50,635	24.41	12
13	Food Service Supervisor					13
14	Head Cook	5,238	5,697	57,177	10.04	14
15	Cook Helpers/Assistants	8,289	9,030	98,594	10.92	15
16	Dishwashers					16
17	Maintenance Workers	2,119	2,727	42,971	15.76	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,970	2,078	81,291	39.12	20
21	Assistant Administrator					21
22	Other Administrative	231	231	21,813	94.43	22
23	Office Manager					23
24	Clerical	2,248	2,505	46,347	18.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,940	2,086	37,999	18.22	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	576	576	20,593	35.75	33
34	TOTAL (lines 1 - 33)	113,717	124,257	\$ 2,147,905 *	\$ 17.29	34

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

** See instructions.

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	146	\$ 6,868	01-03	35
36	Medical Director	Monthly	27,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	4	229	10-03	38
39	Pharmacist Consultant	Monthly	8,960	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	42	2,137	11-03	44
45	Social Service Consultant	36	2,490	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	228	\$ 47,684		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

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe Pav Hlth Treatmnt Ctr

0040071

Report Period Beginning:

01/01/13

Ending:

12/31/13

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 \$19,195
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line _____
- (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. \$ 272,787
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 10,760 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.