



Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288 Report Period Beginning: 01/01/17 Ending: 12/31/17

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	136	Intermediate (ICF)	136	49,640	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	136	TOTALS	136	49,640	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	36,055	506	4,309	40,870	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,055	506	4,309	40,870	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.33%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0054288 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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
	<b>A. General Services</b>										
1	Dietary	230,522	15,042	6,858	252,422		252,422		252,422		1
2	Food Purchase		175,058		175,058	(10,760)	164,298	(22)	164,276		2
3	Housekeeping			157,630	157,630		157,630		157,630		3
4	Laundry		90,345		90,345		90,345		90,345		4
5	Heat and Other Utilities			171,553	171,553		171,553	(705)	170,848		5
6	Maintenance	36,825		198,261	235,086		235,086	15,053	250,139		6
7	Other (specify):*							2,183	2,183		7
8	<b>TOTAL General Services</b>	267,347	280,445	534,302	1,082,094	(10,760)	1,071,334	16,509	1,087,843		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,500	10,500		10,500		10,500		9
10	Nursing and Medical Records	1,040,164	65,181	102,321	1,207,666		1,207,666	67,104	1,274,770		10
10a	Therapy										10a
11	Activities	13,079		2,970	16,049		16,049		16,049		11
12	Social Services	195,979			195,979		195,979		195,979		12
13	CNA Training										13
14	Program Transportation			6,167	6,167		6,167	(428)	5,739		14
15	Other (specify):*							14,272	14,272		15
16	<b>TOTAL Health Care and Programs</b>	1,249,222	65,181	121,958	1,436,361		1,436,361	80,948	1,517,309		16
	<b>C. General Administration</b>										
17	Administrative	110,807		231,483	342,290		342,290	(187,750)	154,540		17
18	Directors Fees										18
19	Professional Services			199,126	199,126		199,126	336	199,462		19
20	Dues, Fees, Subscriptions & Promotions			34,838	34,838		34,838	(887)	33,951		20
21	Clerical & General Office Expenses	106,850	570	269,103	376,523		376,523	(40,086)	336,437		21
22	Employee Benefits & Payroll Taxes			314,833	314,833	10,760	325,593		325,593		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,860	3,860		3,860	879	4,739		24
25	Other Admin. Staff Transportation			45	45		45	5,224	5,269		25
26	Insurance-Prop.Liab.Malpractice			161,180	161,180		161,180	1,980	163,160		26
27	Other (specify):*							32,663	32,663		27
28	<b>TOTAL General Administration</b>	217,657	570	1,214,468	1,432,695	10,760	1,443,455	(187,642)	1,255,813		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,734,226	346,196	1,870,728	3,951,150		3,951,150	(90,185)	3,860,965		29

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

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

#0054288

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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	
	<b>D. Ownership</b>											
30	Depreciation			71,220	71,220		71,220	(23,826)	47,394			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,804	48,804		48,804	275,498	324,302			32
33	Real Estate Taxes			193,526	193,526		193,526	101,236	294,762			33
34	Rent-Facility & Grounds			473,086	473,086		473,086	(469,284)	3,802			34
35	Rent-Equipment & Vehicles			16,038	16,038		16,038	2,726	18,764			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			802,674	802,674		802,674	(113,649)	689,025			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		10,801		10,801		10,801		10,801			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			72,727	72,727		72,727	(72,727)				43
44	<b>TOTAL Special Cost Centers</b>		10,801	72,727	83,528		83,528	(72,727)	10,801			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,734,226	356,997	2,746,129	4,837,352		4,837,352	(276,561)	4,560,791			45

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

Facility Name & ID Number **Monroe Pavilion Health Ctr.**

# **0054288**

Report Period Beginning:

**01/01/17**

Ending:

**12/31/17**

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(2,063)	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	(154,602)	30		9
10	Interest and Other Investment Income	(13,054)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(22)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,070)	21		18
19	Entertainment				19
20	Contributions	(3,250)	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	(190,788)	21		24
25	Fund Raising, Advertising and Promotional	(261)	21		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	(121,778)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (487,888)		\$	30

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	211,327		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 211,327		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (276,561)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Monroe Pavilion Health Ctr.

ID# 0054288

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (1,271)	21	1
2	Veterans' Expenses	(24,315)	10	2
3	Bank Charges	(10,493)	21	3
4	Marketing Consultant	(69,895)	43	4
5	Marketing Materials	(2,832)	43	5
6	Patient Needs	(507)	10	6
7	Alliance for Living PAC Dues	(1,843)	20	7
8	Out of Period Professional	(416)	19	8
9	Bldg Co. - Penalties	(8,098)	21	9
10	Non-Allowable Legal	(2,108)	19	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				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	<b>Total</b>	(121,778)		49

Monroe Pavilion Health Ctr.

Report Period Beginning:                     ID# 0054288                      
 Ending:   01/01/17                      
  12/31/17                    

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Monroe Pavilion Health Ctr.# 0054288

Report Period Beginning:

01/01/17

Ending:

12/31/17

## 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	(22)											(22)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,063)		1,358									(705)	5
6	Maintenance			15,053									15,053	6
7	Other (specify):*			2,183									2,183	7
8	<b>TOTAL General Services</b>	<b>(2,085)</b>		<b>18,594</b>									<b>16,509</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(24,822)		91,926									67,104	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation					(428)							(428)	14
15	Other (specify):*			14,272									14,272	15
16	<b>TOTAL Health Care and Programs</b>	<b>(24,822)</b>		<b>106,198</b>		<b>(428)</b>							<b>80,948</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(187,750)									(187,750)	17
18	Directors Fees													18
19	Professional Services	(2,524)	(1,715)	4,575									336	19
20	Fees, Subscriptions & Promotions	(5,093)		4,206									(887)	20
21	Clerical & General Office Expenses	(212,981)	8,098	164,797									(40,086)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			879									879	24
25	Other Admin. Staff Transportation			5,224									5,224	25
26	Insurance-Prop.Liab.Malpractice			1,980									1,980	26
27	Other (specify):*			32,663									32,663	27
28	<b>TOTAL General Administration</b>	<b>(220,598)</b>	<b>6,383</b>	<b>26,573</b>									<b>(187,642)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(247,505)</b>	<b>6,383</b>	<b>151,365</b>		<b>(428)</b>							<b>(90,185)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Monroe Pavilion Health Ctr. # 0054288 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(154,602)	127,034	3,742									(23,826)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,054)	279,560	8,992									275,498	32
33	Real Estate Taxes		98,840	2,396									101,236	33
34	Rent-Facility & Grounds		(473,086)	3,802									(469,284)	34
35	Rent-Equipment & Vehicles			2,726									2,726	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(167,656)</b>	<b>32,348</b>	<b>21,659</b>									<b>(113,649)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(72,727)											(72,727)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(72,727)</b>											<b>(72,727)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(487,888)</b>	<b>38,731</b>	<b>173,024</b>		<b>(428)</b>							<b>(276,561)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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 Rental Income	\$ 473,086	Monroe Pavilion Associates	100.00%	\$	(473,086)	1
2	V	32 Interest	124	Monroe Pavilion Associates	100.00%	279,684	279,560	2
3	V	19 Accounting Fees	1,715	Monroe Pavilion Associates	100.00%		(1,715)	3
4	V	30 Depreciation		Monroe Pavilion Associates	100.00%	127,034	127,034	4
5	V	21 Penalties		Monroe Pavilion Associates	100.00%	8,098	8,098	5
6	V	33 Real Estate Taxes		Monroe Pavilion Associates	100.00%	98,840	98,840	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 474,925			\$ 513,656	\$ * 38,731	14

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

**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	\$	MAESTRO CONSULTING SERVICES LLC	100.00%	\$ 1,358	\$	1,358	15
16	V	6 MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	12,042		12,042	16
17	V	6 MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	3,011		3,011	17
18	V	7 EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	2,183		2,183	18
19	V	10 CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	78,221		78,221	19
20	V	10 CONTRACT NURSING		MAESTRO CONSULTING SERVICES LLC	100.00%	13,705		13,705	20
21	V	15 EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	14,272		14,272	21
22	V	17 ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	43,733		43,733	22
23	V	19 PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	4,575		4,575	23
24	V	20 DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	4,206		4,206	24
25	V	21 CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	140,964		140,964	25
26	V	21 CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	23,833		23,833	26
27	V	24 SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	879		879	27
28	V	25 TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	5,224		5,224	28
29	V	26 INSURANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	1,980		1,980	29
30	V	27 EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	32,663		32,663	30
31	V	30 DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	3,742		3,742	31
32	V	32 INTEREST EXPENSE		MAESTRO CONSULTING SERVICES LLC	100.00%	8,992		8,992	32
33	V	33 REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	2,396		2,396	33
34	V	34 BUILDING RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	3,802		3,802	34
35	V	35 EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	633		633	35
36	V	35 AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	2,093		2,093	36
37	V								37
38	V	17 MANAGEMENT FEE	231,483	MAESTRO CONSULTING SERVICES LLC	100.00%			(231,483)	38
39	Total		\$ 231,483			\$ 404,507	\$ *	173,024	39

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning: 01/01/17

Ending: 12/31/17

**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	\$ 20,274	MAPLE LEAF	100.00%	\$ 20,274		15
16	V	26 LIABILITY INSURANCE	179,536	MAPLE LEAF	100.00%	179,536		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	<b>Total</b>		\$ 199,810			\$ 199,810	\$ *	39

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

**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	14 Transportation	\$ 3,875	Lifeline Ambulance LLC		\$ 3,447	\$(428)
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	<b>Total</b>		\$ 3,875			\$ 3,447	\$ * (428)

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

**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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning: 01/01/17

Ending: 12/31/17

**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	<b>Total</b>		\$			\$	\$ *	39

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

**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	<b>Total</b>		\$			\$	\$ *	39

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

**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	<b>Total</b>		\$			\$	\$ *	39

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

**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	<b>Total</b>		\$			\$	\$ *	39

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

**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	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name & ID Number Monroe Pavilion Health Ctr. # 0054288 Report Period Beginning: 01/01/17 Ending: 12/31/17

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										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

1	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	1,835,856	28	\$ 50,076	\$ 49,776	\$ 1,358	1	
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	444,128	444,128	49,776	12,042	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,835,856	28	111,048	49,776	3,011	3	
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,835,856	28	80,529	49,776	2,183	4	
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	2,884,957	2,884,957	49,776	78,221	5
6	10	CONTRACT NURSING	AVAIL. CENSUS DAYS	1,835,856	28	505,476	49,776	13,705	6	
7	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,835,856	28	526,402	49,776	14,272	7	
8	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,835,856	28	1,612,976	1,612,976	49,776	43,733	8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,835,856	28	168,752	49,776	4,575	9	
10	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,835,856	28	155,112	49,776	4,206	10	
11	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,835,856	28	5,199,066	5,199,066	49,776	140,964	11
12	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,835,856	28	879,035	49,776	23,833	12	
13	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,835,856	28	32,418	49,776	879	13	
14	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,835,856	28	192,674	49,776	5,224	14	
15	26	INSURANCE	AVAIL. CENSUS DAYS	1,835,856	28	73,017	49,776	1,980	15	
16	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,835,856	28	1,204,673	49,776	32,663	16	
17	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,835,856	28	138,011	49,776	3,742	17	
18	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,835,856	28	331,638	49,776	8,992	18	
19	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,835,856	28	88,385	49,776	2,396	19	
20	34	BUILDING RENTAL	AVAIL. CENSUS DAYS	1,835,856	28	140,244	49,776	3,802	20	
21	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,835,856	28	23,351	49,776	633	21	
22	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,835,856	28	77,202	49,776	2,093	22	
23									23	
24									24	
25	TOTALS					\$ 14,919,170	\$ 10,141,128	\$ 404,507	25	

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

1	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		\$	\$		\$ 20,274	1
2	26	LIABILITY INSURANCE	Direct Allocation					179,536	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				\$	\$		\$ 199,810	25

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending: 12/31/17

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

1	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	14	Transportation	Direct Allocation		\$	\$		\$ 3,447	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				\$	\$		\$ 3,447	25

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending:

12/31/17

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	HUD Loan		X	Mortgage			\$	5,517,623		\$	279,684	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Private Bank		X	Note Payable				839,954			48,804	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$	6,357,577		\$	328,488	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(13,054)	10								
11	Bldg. Co. - Interest Income		X								(124)	11								
12	Allocated form Maestro Consulting		X								8,992	12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$			\$	(4,186)	14								
15	<b>TOTALS (line 9+line14)</b>						\$	6,357,577		\$	324,302	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line #      N/A

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

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







Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288 Report Period Beginning:

01/01/17 Ending:

12/31/17

**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>	<u>1</u>
2	<u>Allocated - Maestro 7257 Lincoln</u>		<u>2004</u>	<u>4,338</u>	<u>2</u>
3	<b>TOTALS</b>	<b>39,159</b>		<b>\$ 34,802</b>	<b>3</b>

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	\$ 127,034	26	\$	\$(127,034)	\$ 2,116,772	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1986	32,967		20			32,967	9
10	Various		1987	4,735		20			4,735	10
11	Various		1988	8,738		20			8,738	11
12	Various		1989	11,001		20			11,001	12
13	Various		1990	1,919		20			1,919	13
14	Various		1991	5,128		20			5,128	14
15	Various		1992	4,600		20			4,600	15
16	Various		1993	17,616		20			17,616	16
17	Various		1994	13,951		20	358	358	8,334	17
18	Various		1995	13,124		20			13,119	18
19	Various		1996	19,194		20			18,957	19
20	Various		1997	32,365		20	738	738	32,326	20
21	Various		1998	50,879		20	2,544	2,544	49,233	21
22	Various		1999	63,549		20	3,177	3,177	59,281	22
23	Various		2000	62,515		20	3,126	3,126	55,376	23
24	Various		2001	42,063		20	2,103	2,103	34,922	24
25	Various		2002	32,776		20	1,164	1,164	25,268	25
26	Various		2003	195,702		20	320	320	194,016	26
27	Various		2004	5,054		20	134	134	4,204	27
28	Various		2005	4,804		20	35	35	4,525	28
29	Various		2006	143,838		20	5,335	5,335	101,155	29
30	Various		2009	8,032		20	686	686	5,977	30
31	Various		2011	34,145		20	3,415	3,415	22,098	31
32	Various		2012	57,309		20	5,731	5,731	32,469	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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		94,391			4,719	4,719	39,236	67
68		65,231	1,239		2,448	1,209	29,170	68
69			71,220			(71,220)		69
70		\$ 3,142,398	\$ 199,493		\$ 36,032	\$ (163,461)	\$ 2,933,141	70

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,142,398	\$ 199,493		\$ 36,032	\$ (163,461)	\$ 2,933,141	1
2	Repair Elevator Door	2014	4,343		20	217	217	778	2
3	Water Pump Replacement	2015	3,397		20	679	679	1,642	3
4	Boiler - Wile McClain Model # 888-S Steam Boiler	2015	33,451		20	1,673	1,673	5,018	4
5	Door Improvements - Doors Done Right	2015	3,646		20	182	182	441	5
6	Galvanized Steel Insulated Door	2016	8,484		20	218	218	245	6
7	Elevator - Installed New Cylinder	2016	36,800		20	944	944	1,140	7
8	Elevator Hydraulic Valve & Oil Cooler	2017	9,250		20	1,542	1,542	1,542	8
9	Air Conditioner	2017	4,409		20	514	514	514	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)		\$ 3,246,178	\$ 199,493		\$ 42,000	\$ (157,493)	\$ 2,944,460	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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		\$ 3,246,178	\$ 199,493		\$ 42,000	\$ (157,493)	\$ 2,944,460	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		\$ 3,246,178	\$ 199,493		\$ 42,000	\$ (157,493)	\$ 2,944,460	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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		\$ 3,246,178	\$ 199,493		\$ 42,000	\$ (157,493)	\$ 2,944,460	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)	\$ 3,246,178	\$ 199,493		\$ 42,000	\$ (157,493)	\$ 2,944,460	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending:

12/31/17

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		\$ 3,246,178	\$ 199,493		\$ 42,000	\$ (157,493)	\$ 2,944,460	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)	\$ 3,246,178	\$ 199,493		\$ 42,000	\$ (157,493)	\$ 2,944,460	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2004	5,493		20	275	275	5,030	9
10	Various	2005	11,502		20	574	574	10,357	10
11	Drapery Panel; Curtains	2007	19,724		20	986	986	9,860	11
12	Fire Pump	2013	49,072		20	2,454	2,454	12,269	12
13	Stairs Work	2014	8,600		20	430	430	1,720	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 94,391	\$		\$ 4,719	\$ 4,719	\$ 39,236	34

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending:

12/31/17

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		\$ 94,391	\$		\$ 4,719	\$	\$ 39,236	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 94,391	\$		\$ 4,719	\$	\$ 39,236	34

\*\*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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated - Maestro 7257 Lincoln	2004	39,043	1,001	35	1,116	115	15,757	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - Maestro Consulting	2003	318		20	16	16	224	9
10	Allocated - Maestro Consulting	2004	6,448		20	322	322	4,425	10
11	Allocated - Maestro Consulting	2005	382		20	19	19	246	11
12	Allocated - Maestro Consulting	2006	518		20	26	26	295	12
13	Allocated - Maestro Consulting	2008	546		20	27	27	253	13
14	Allocated - Maestro Consulting	2009	8,796		20	440	440	3,787	14
15	Allocated - Maestro Consulting	2010	1,352		20	68	68	507	15
16	Allocated - Maestro Consulting	2011	73		20	4	4	25	16
17	Allocated - Maestro Consulting	2012	81		20	4	4	23	17
18	Allocated - Maestro Consulting	2014	1,017		20	51	51	183	18
19	Allocated - Maestro Consulting	2015	286		20	14	14	33	19
20	Allocated - Maestro Consulting	2016	1,253	160	20	125	(35)	174	20
21	Allocated - Maestro Consulting	2017	168		20	8	8	8	21
22									22
23	Allocated - Maestro 7257 Lincoln	2015	615	53	20	41	(12)	96	23
24	Allocated - Maestro 7257 Lincoln	2005	3,559	25	20	128	103	2,610	24
25	Allocated - Maestro 7257 Lincoln	2004	776		20	39	39	524	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 65,231	\$ 1,239		\$ 2,448	\$ 1,209	\$ 29,170	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 65,231	\$ 1,239		\$ 2,448	\$ 1,209	\$ 29,170
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 65,231	\$ 1,239		\$ 2,448	\$ 1,209	\$ 29,170

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	\$ 248,546	\$ 382	\$ 3,994	\$ 3,612	10	\$ 159,014	71
72	Current Year Purchases	11,347	2,121	1,135	(986)	10	1,135	72
73	Fully Depreciated Assets	224,875		265	265	10	224,875	73
74								74
75	TOTALS	\$ 484,768	\$ 2,503	\$ 5,394	\$ 2,891		\$ 385,024	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 Maestro Consulti	2017	240				5	240	77
78										78
79										79
80	TOTALS			\$ 2,440	\$	\$	\$		\$ 240	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,768,188	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 201,996	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,394	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (154,602)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,329,724	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning: 01/01/17

Ending: 12/31/17

**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 - Maestro Consutling</u>				<u>3,802</u>			5
6								6
7	<b>TOTAL</b>				\$ <b>3,802</b>			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.	<u>                    /2018</u>	\$ <u>                    </u>
13.	<u>                    /2019</u>	\$ <u>                    </u>
14.	<u>                    /2020</u>	\$ <u>                    </u>

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: \$ 16,670 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 - Maestro Consulting</u>		\$	<u>2,093</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	<b>2,093</b>	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.

**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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				10,636		10,636	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____						165		165	13
14	<b>TOTAL</b>			\$		\$	10,801		\$ 10,801	14

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

Facility Name & ID Number Monroe Pavilion Health Ctr.# 0054288Report Period Beginning: 01/01/17Ending: 12/31/17

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,800	\$ 2,800	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	3,114,046	3,123,810	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	143,319	143,319	6
7	Other Prepaid Expenses		110,999	7
8	Accounts Receivable (owners or related parties)		59,812	8
9	Other(specify): <u>See Attached Schedule</u>		24,398	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,260,165	\$ 3,465,138	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		437,264	13
14	Buildings, at Historical Cost		4,568,900	14
15	Leasehold Improvements, at Historical Cost	849,902	849,902	15
16	Equipment, at Historical Cost	454,455	734,331	16
17	Accumulated Depreciation (book methods)	(1,158,651)	(4,637,601)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		136,018	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(51,490)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	542,920	1,759,678	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 688,626	\$ 3,797,002	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,948,791	\$ 7,262,140	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,968,715	\$ 1,969,658	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,971	43,099	28
29	Short-Term Notes Payable	839,954	956,513	29
30	Accrued Salaries Payable	121,333	121,333	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,636	24,636	31
32	Accrued Real Estate Taxes(Sch.IX-B)	81,802	278,694	32
33	Accrued Interest Payable	94	462,998	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	2,123,927	2,123,927	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 5,188,432	\$ 5,980,858	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,401,064	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,401,064	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,188,432	\$ 11,381,922	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,239,641)	\$ (4,119,782)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,948,791	\$ 7,262,140	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,042,831)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Late Journal Entries</b>	<b>(22,649)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,065,480)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(174,161)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(174,161)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,239,641)</b>	<b>24</b> *

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

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,648,866	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,648,866	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	13,054	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 13,054	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	1,271	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,271	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,663,191	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,082,094	31
32	Health Care	1,436,361	32
33	General Administration	1,432,695	33
<b>B. Capital Expense</b>			
34	Ownership	802,674	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	83,528	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,837,352	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(174,161)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (174,161)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,102,283	44
45	Private Pay - Net Inpatient Revenue	65,780	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <b>Veteran</b>	282,986	47
48	Other-(specify) <b>Managed Care</b>	197,817	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,648,866	49

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

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

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

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

Facility Name & ID Number Monroe Pavilion Health Ctr.

# 0054288

Report Period Beginning:

01/01/17

Ending:

12/31/17

**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	1,909	2,113	\$ 81,426	\$ 38.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	392	399	12,394	31.06	3
4	Licensed Practical Nurses	16,247	17,687	449,841	25.43	4
5	CNAs & Orderlies	30,985	35,565	457,445	12.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	291	466	7,090	15.21	9
10	Activity Assistants	286	500	5,989	11.98	10
11	Social Service Workers	10,154	11,072	195,979	17.70	11
12	Dietician					12
13	Food Service Supervisor	1,941	2,190	58,456	26.69	13
14	Head Cook	4,775	5,523	67,443	12.21	14
15	Cook Helpers/Assistants	7,522	8,353	104,623	12.53	15
16	Dishwashers					16
17	Maintenance Workers	1,930	2,086	36,825	17.65	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,821	2,086	110,807	53.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,815	4,429	106,850	24.13	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	1,597	2,013	39,058	19.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	83,665	94,482	\$ 1,734,226 *	\$ 18.36	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	144	\$ 6,858	01-03	35
36	Medical Director	Monthly	10,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	72,443	10-03	38
39	Pharmacist Consultant	Monthly	14,258	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	54	2,970	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultatnt	Monthly	12,020	10-03	47
48	Dental Consultant	Monthly	3,600	10-03	48
49	TOTAL (lines 35 - 48)	198	\$ 122,649		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

Facility Name & ID Number **Monroe Pavilion Health Ctr.**

# **0054288**

Report Period Beginning: **01/01/17**

Ending: **12/31/17**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Linda Williams	Administrator	0	\$ 110,807	Workers' Compensation Insurance	\$ 103,484	IDPH License Fee	\$	
				Unemployment Compensation Insurance	47,515	Advertising: Employee Recruitment	529	
				FICA Taxes	130,131	Health Care Worker Background Check	3,904	
				Employee Health Insurance	13,201	(Indicate # of checks performed <u>167.8</u> )		
				Employee Meals	10,760	Patient Background Checks	2,600	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	16,142	
				Pension Plan	14,272	Licenses and Permits	6,570	
				Employee Benefits - Other	4,573	Allocated - Maestro Consulting	4,206	
				Employee Physicals	1,656			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 110,807	TOTAL (agree to Schedule V, line 22, col.8)		\$ 325,592	TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Maestro Consulting - Bookkeeping Fees			\$ 231,483				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	3,860
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 231,483	TOTAL		\$	Allocated - Maestro Consulting	879
C. Professional Services							Entertainment Expense ( )	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Marcum LLP	Accounting		\$ 20,156				TOTAL	\$ 4,739
See Attached	Legal		10,507					
Ability Network	Network Service Vendor		2,698					
Creative Technology Solutions	Data Processing		15,100					
EMMI Solutions	Patient Engagement		293					
Health Data Systems	Payroll Processing		5,554					
Matrixcare	E.H.R.		1,932					
Nexuscomm, LLC	Data Processing		1,813					
Point Click Care	Data Processing		24,959					
Care Cost	Cost Management		4,999					
Corporation Services	Statutory Representation		489					
See Supplemental Schedule			110,626					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 199,126					

\* Attach copy of IMRF notifications

\*\*See instructions.

