

Facility Name & ID Number Momence Meadows Nrsing & Reh

0048033 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1	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	140	Skilled (SNF)	140	51,100	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	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	28,395	850	2,352	31,597	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,395	850	2,352	31,597	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.83%

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

0 (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 07/01/06

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

YES Date 07/01/06 NO

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

YES NO If YES, enter number of beds certified 140 and days of care provided 2,284

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number

Momence Meadows Nrsing & Reh

0048033

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	180,330		27,576	207,906		207,906	1,544	209,450		1
2	Food Purchase		183,702		183,702		183,702		183,702		2
3	Housekeeping	159,462	28,814		188,276		188,276		188,276		3
4	Laundry	57,404	10,215		67,619		67,619		67,619		4
5	Heat and Other Utilities			149,552	149,552		149,552	1,984	151,536		5
6	Maintenance	32,428	33,316	49,114	114,858		114,858	1,365	116,223		6
7	Other (specify):*										7
8	TOTAL General Services	429,624	256,047	226,242	911,913		911,913	4,893	916,806		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,701,971	260,708	5,628	1,968,307		1,968,307	18,558	1,986,865		10
10a	Therapy			391,167	391,167		391,167		391,167		10a
11	Activities	82,019	16,036		98,055		98,055		98,055		11
12	Social Services	36,160		1,404	37,564		37,564		37,564		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* RX Consultant			9,324	9,324		9,324		9,324		15
16	TOTAL Health Care and Programs	1,820,150	276,744	425,523	2,522,417		2,522,417	18,558	2,540,975		16
	C. General Administration										
17	Administrative	87,756			87,756		87,756	(5,484)	82,272		17
18	Directors Fees										18
19	Professional Services			335,989	335,989		335,989	(266,823)	69,166		19
20	Dues, Fees, Subscriptions & Promotions			1,493	1,493		1,493		1,493		20
21	Clerical & General Office Expenses	103,217	24,334	(102,899)	24,652		24,652	100,079	124,731		21
22	Employee Benefits & Payroll Taxes			645,534	645,534		645,534	26,553	672,087		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,780	4,780		4,780	1,679	6,459		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			236,099	236,099		236,099	44,844	280,943		26
27	Other (specify):*										27
28	TOTAL General Administration	190,973	24,334	1,120,996	1,336,303		1,336,303	(99,152)	1,237,151		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,440,747	557,125	1,772,761	4,770,633		4,770,633	(75,701)	4,694,932		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

Momence Meadows Nrsing & Reh

#0048033

Report Period Beginning:

01/01/15

Ending:

12/31/15

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			27,134	27,134		27,134	232,892	260,026			30
31	Amortization of Pre-Op. & Org.			2,825	2,825		2,825	238,737	241,562			31
32	Interest			340,063	340,063		340,063	236,518	576,581			32
33	Real Estate Taxes							89,330	89,330			33
34	Rent-Facility & Grounds			1,038,000	1,038,000		1,038,000	(1,033,026)	4,974			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,408,022	1,408,022		1,408,022	(235,549)	1,172,473			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,312	1,312		1,312		1,312			38
39	Ancillary Service Centers		162,601		162,601		162,601		162,601			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			255,430	255,430		255,430		255,430			42
43	Other (specify):* Bad Debt Exp			110,000	110,000		110,000	(110,000)				43
44	TOTAL Special Cost Centers		162,601	366,742	529,343		529,343	(110,000)	419,343			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,440,747	719,726	3,547,525	6,707,998		6,707,998	(421,250)	6,286,748			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 Momence Meadows Nrsing & Reh

0048033

Report Period Beginning: 01/01/15

Ending: 12/31/15

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	160,097	30		9
10	Interest and Other Investment Income	(1,077)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(26)	1		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	(6,726)	21		18
19	Entertainment				19
20	Contributions	200	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(110,000)	43		24
25	Fund Raising, Advertising and Promotional	(8,338)	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	(25,147)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 8,983		\$	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)	(430,233)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (430,233)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (421,250)		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.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Momence Meadows Nrsing & Reh

ID# 0048033

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line
Reference

NON-ALLOWABLE EXPENSES

Amount

		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (25,147)	21	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				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		(25,147)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Momence Meadows Nrsing & Reh# 0048033

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(26)	1,570	0	0	0	0	0	0	0	0	0	1,544	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,984	0	0	0	0	0	0	0	0	0	1,984	5
6	Maintenance	0	1,365	0	0	0	0	0	0	0	0	0	1,365	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(26)	4,919	0	0	0	0	0	0	0	0	0	4,893	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	18,558	0	0	0	0	0	0	0	0	0	18,558	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	18,558	0	0	0	0	0	0	0	0	0	18,558	16
	C. General Administration													
17	Administrative	0	(5,484)	0	0	0	0	0	0	0	0	0	(5,484)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(299,784)	32,961	0	0	0	0	0	0	0	0	(266,823)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(40,011)	139,527	563	0	0	0	0	0	0	0	0	100,079	21
22	Employee Benefits & Payroll Taxes	0	26,553	0	0	0	0	0	0	0	0	0	26,553	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,679	0	0	0	0	0	0	0	0	0	1,679	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,341	42,503	0	0	0	0	0	0	0	0	44,844	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(40,011)	(135,168)	76,027	0	(99,152)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(40,037)	(111,691)	76,027	0	(75,701)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Momence Meadows Nrsing & Reh# 0048033

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	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	160,097	0	72,795	0	0	0	0	0	0	0	0	232,892	30
31	Amortization of Pre-Op. & Org.	0	0	238,737	0	0	0	0	0	0	0	0	238,737	31
32	Interest	(1,077)	0	237,595	0	0	0	0	0	0	0	0	236,518	32
33	Real Estate Taxes	0	3,442	85,888	0	0	0	0	0	0	0	0	89,330	33
34	Rent-Facility & Grounds	0	4,974	(1,038,000)	0	0	0	0	0	0	0	0	(1,033,026)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	159,020	8,416	(402,985)	0	(235,549)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(110,000)	0	0	0	0	0	0	0	0	0	0	(110,000)	43
44	TOTAL Special Cost Centers	(110,000)	0	0	0	0	0	0	0	0	0	0	(110,000)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	8,983	(103,275)	(326,958)	0	0	0	0	0	0	0	0	(421,250)	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
Michael Blisko	31.50	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
Moishe Gubin	33.60	Belhaven Nursing & Rehab Center	Chicago	Momence Meadows Realty, LLC		Realty Co
A & F realty	31.50	City View Multicare Center	Cicero			
Bernard Steinberg	3.40	Continental Nursing & Rehab Center	Chicago			
		Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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	1 Dietary	\$ 6,741	Infinity Healthcare Management		\$ 8,311	\$ 1,570	1
2	V	10 Nursing Wages	20,767	Infinity Healthcare Management		39,325	18,558	2
3	V	21 Office Wages		Infinity Healthcare Management		162,198	162,198	3
4	V	5 Utilities		Infinity Healthcare Management		1,984	1,984	4
5	V	6 Maintenance		Infinity Healthcare Management		1,365	1,365	5
6	V	19 Professional Services	300,638	Infinity Healthcare Management		854	(299,784)	6
7	V	21 Office Expense	36,712	Infinity Healthcare Management		14,041	(22,671)	7
8	V	22 Employee Benefit	3,362	Infinity Healthcare Management		29,915	26,553	8
9	V	24 Auto/Travel Expense	507	Infinity Healthcare Management		2,186	1,679	9
10	V	26 Insurance		Infinity Healthcare Management		2,341	2,341	10
11	V	33 Property Tax		Infinity Healthcare Management		3,442	3,442	11
12	V	34 Rent		Infinity Healthcare Management		4,974	4,974	12
13	V	17 Administrative	5,484	Infinity Healthcare Management			(5,484)	13
14	Total		\$ 374,211			\$ 270,936	\$ * (103,275)	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	19 Professional Fees	\$	Momence Meadows Realty, LLC		\$ 32,961	\$ 32,961	15
16	V	21 Office Expense		Momence Meadows Realty, LLC		563	563	16
17	V	26 Insurance		Momence Meadows Realty, LLC		42,503	42,503	17
18	V	30 Depreciation		Momence Meadows Realty, LLC		72,795	72,795	18
19	V	31 Amortization		Momence Meadows Realty, LLC		238,737	238,737	19
20	V	32 Interest		Momence Meadows Realty, LLC		237,595	237,595	20
21	V	33 Property Taxes		Momence Meadows Realty, LLC		85,888	85,888	21
22	V	34 Rent	1,038,000	Momence Meadows Realty, LLC			(1,038,000)	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		\$ 1,038,000			\$ 711,042	\$ * (326,958)	39

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

Facility Name & ID Number

Momence Meadows Nrsing & Reh

0048033

Report Period Beginning:

01/01/15

Ending:

12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streator				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomington				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Momence Meadows Nrsing & Reh

0048033

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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	Reporting Period Interest Expense				
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO										Original	Balance		
A. Directly Facility Related																
Long-Term																
1	HUD		x	mortgage	\$35,001.00	8/21/13	\$ 6,360,700	\$ 5,962,810	10/1/36	3.9400	\$ 237,595	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6	Capital One		x	working capital	None	8/31/14	26,000,000	550,665	8/31/18	various	66,455	6				
7	Infinity Funding	x		working capital	None	various	2,735,000	2,267,183	various	various	273,608	7				
8												8				
9	TOTAL Facility Related				\$35,001.00		\$ 35,095,700	\$ 8,780,658			\$ 577,658	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 35,095,700	\$ 8,780,658			\$ 577,658	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 33,253 Line # 26

* 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.)

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 2014 report.		\$	37,018		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.)		\$	85,332		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	48,314		3														
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	41,016		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.)		\$			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.		\$	89,330		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	42,004	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	45,089	9																
	2012	74,060	10																
	2013	83,362	11																
	2014	85,332	12																

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Momence Meadows Nrsing & Reh COUNTY Kankakee
 FACILITY IDPH LICENSE NUMBER 0048033
 CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar
 TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-11-19-306-007</u>	<u>Nursing Home</u>	\$ <u>85,331.96</u>	\$ <u>85,331.96</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>85,331.96</u></u>	\$ <u><u>85,331.96</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? YES X NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number Momence Meadows Nrsing & Reh

0048033 Report Period Beginning:

01/01/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,850 B. General Construction Type: Exterior BRICK Frame CONCRETE/STEEL Number of Stories 1

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: 270,340 2. Number of Years Over Which it is Being Amortized: 15
 3. Current Period Amortization: 171,223 4. Dates Incurred: PRIOR TO 07/01/06

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>		<u>7/1/2006</u>	<u>\$ 180,000</u>	1
2					2
3	TOTALS			\$ 180,000	3

Facility Name & ID Number Momence Meadows Nrsing & Reh

0048033

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	1	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	140		2006		\$ 2,839,000	\$ 72,795	39	\$ 72,795	\$ (0)	\$ 564,298	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Nurse Call Light	11/30/2006		26,050	668	39	668		6,680	9
10		A/C on Roof	1/20/2007		420	11	39	11		92	10
11		A/C on Roof	2/16/2007		4,424	113	39	113		963	11
12		Nurse Call System	5/30/2007		280	7	39	7		61	12
13		Replace Locks	11/15/2007		7,700	197	39	197		1,677	13
14		Replace Locks	11/15/2007		104	3	39	3		23	14
15		Exhaust Vent and Filter	11/27/2007		932	24	39	24		203	15
16		Shower Remodeling	6/20/2008		3,750	96		96		769	16
17		New Compressor on Walk In Freezer	1/24/2008		2,158	55	39	55		442	17
18		Sidewalks	3/10/2008		4,289	110	39	110		880	18
19		Asphalt Driveway	4/9/2008		5,775	148	39	148		1,184	19
20		Asphalt Driveway	4/22/2008		5,775	148	39	148		1,184	20
21		Shower Room Tiles	4/30/2008		9,483	243	39	243		1,945	21
22		Drywall, Ultrasteel, Concrete, Sand, etc	5/31/2008		1,129	29	39	29		232	22
23		Mortar	6/8/2008		321	8	39	8		66	23
24		Grout and Mortar	6/20/2008		83	2	39	2		17	24
25		Drywall, Mortar and Paint	7/1/2008		523	13	39	13		107	25
26		Adhesive, Mortar, etc	7/5/2008		597	15	39	15		122	26
27		Adhesive, Mortar, etc	7/15/2008		126	3	39	3		26	27
28		Misc Supplies for Shower Remodeling	7/31/2008		61	2	39	2		13	28
29		Replace Heat Exchanger in Kitchen Roof-Top	12/11/2008		2,936	75	39	75		602	29
30		Carpet	12/29/2009		4,480	115	39	115		804	30
31		Remodeling (Nurse Station, Ceiling, Lighting, Wallpaper)	2/16/2009		108,504	2,782	39	2,782		19,478	31
32		Roof Improvements	4/5/2009		3,500	90	39	90		629	32
33		Roof Improvements	12/21/2009		3,500	90	39	90		629	33
34		Building & Shower Remodeling w/ Towel Rack	11/2/2010		1,714	44	39	44		264	34
35		Shower Remodeling & Wall Base Lining	11/17/2010		1,500	38	39	38		230	35
36		Fire Sprinkler	12/24/2010		1,395	36	39	36		215	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 Momence Meadows Nrsing & Reh

0048033

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	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	
37	Paint, Materials, and Wall Repairs	11/23/2010	\$ 7,900	\$ 203	39	\$ 203	\$	\$ 1,215	37
38	Maintenance, Repairs, Replacements & Wages	11/23/2010	4,485	115	39	115		690	38
39	Materials	12/9/2010	1,482	38	39	38		228	39
40	Materials for Hot Water Valve & Labor	3/30/2010	1,814	47	39	47		279	40
41	Supplies	11/18/2010	1,536	39	39	39		236	41
42	Replace Flame Sensor/Ignitor & Labor	12/1/2010	856	22		22		132	42
43	Partial Billing for Cooler Replacement	12/8/2010	2,445	63	39	63		376	43
44	Repatched Walls, Resealed Gravel, Reflashed Drain	3/19/2010	1,650	42	39	42		253	44
45	New Soffit and Installed SPMB Patch	4/12/2010	950	24	39	24		146	45
46	Installed New Shingle Roof & Repaired Rotted Wood	11/22/2010	3,950	101	39	101		607	46
47	Remove Snow, Applied Patch to Roof, Patched 2 Holes	12/27/2010	750	19	39	19		115	47
48	Cabling for New TV Jacks (\$55/jack)	5/24/2010	8,000	205	39	205		1,230	48
49	Repaired Ramp and Asphalt	11/18/2010	2,395	61	39	61		368	49
50	Repair Leaks on Main Water Supply and Dishwasher	6/8/2011	1,297	33	39	33		166	50
51	Replacement of Heat Exchanger	12/2/2010	1,384	35	39	35		177	51
52	Cooler Replacement	12/14/2010	2,445	63	39	63		314	52
53	Heavy Asphalt Coating to Roof	5/23/2011	950	24	39	24		121	53
54	Patching of roof and Replacement of Shingles	10/24/2011	3,000	77	39	77		385	54
55	Retrofit of light fixtures	4/28/2011	16,446	422	39	422		2,109	55
56	Stone/Steel Work and Concrete Replacement	9/1/2011	750	19	39	19		96	56
57	Stone/Steel Work and Concrete Replacement	9/6/2011	750	19	39	19		96	57
58	Replace heat exchanger	11/2/2012	3,775	97	39	97		387	58
59	Replace compressor in freezer	7/6/2012	3,385	87	39	87		347	59
60		7/2/2012	61,769	1,584	39	1,584		6,334	60
61									61
62	2007 Assets not allowed for increased capital reimbursement	2007	3,936	101	39	101		857	62
63	2008 Assets not allowed for increased capital reimbursement	2008	3,751	96	39	96		769	63
64	2010 Assets not allowed for increased capital reimbursement	2010	7,000	179	39	179		1,076	64
65	2011 Assets not allowed for increased capital reimbursement	2011	5,078	130	39	130		651	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,194,436	\$ 81,905		\$ 81,905	\$ (0)	\$ 623,595	70

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

Facility Name & ID Number Momence Meadows Nrsing & Reh

0048033

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,194,436	\$ 81,905		\$ 81,905	\$ (0)	\$ 623,595	1
2	Vinyl tile	8/27/2013	1,373	35	39	35		88	2
3	Heat Exchanger	5/14/2013	2,670	68	39	68		171	3
4	Sprinkler piping & relocating	3/13/2013	48,000	1,231	39	1,231		3,077	4
5	Survey work for sprinkler piping	2/26/2013	3,600	92	39	92		230	5
6	Vinyl tiles - dining room	9/2/2013	1,375	35	39	35		88	6
7	Electrical wiring - dishwasher	12/5/2013	2,575	66	39	66		165	7
8									8
9	3 water heaters removed & new installed	4/4/2014	23,995	615	39	615		1,231	9
10	Patch wall flashings	5/27/2014	4,850	124	39	124		248	10
11	Nurses station walls / cabinets	5/28/2014	24,900	638	39	638		1,277	11
12	Patch cords & cables	3/6/2014	2,583	66	39	66		132	12
13	GAF roofing system	6/19/2014	63,400	1,626	39	1,626		3,254	13
14	Replace compressor in "C" wing	7/25/2014	3,373	86	39	86		172	14
15	Rental generator	3/27/2014	9,182	235	39	235		470	15
16	New door for walk-in freezer	8/22/2014	3,046	78	39	78		156	16
17	Kitchen flooring / repair leak	8/29/2014	2,253	58	39	58		116	17
18	Install booster pump	8/29/2014	1,700	44	39	44		88	18
19	Electric repairs in kitchen	8/29/2014	5,975	153	39	153		306	19
20	Kitchen flooring / repair leak	9/2/2014	7,550	194	39	194		388	20
21	Remodel & install tile in 2 rooms & bathroom	10/13/2014	1,620	42	39	42		84	21
22	Remodel & install tile in 2 rooms & bathroom	11/9/2014	2,405	62	39	62		124	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)		\$ 3,410,861	\$ 87,453		\$ 87,453	\$ (0)	\$ 635,460	34

**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	\$ 612,812	\$ 10,761	\$ 163,240	\$ 152,479	5	\$ 588,632	71
72	Current Year Purchases	54,120	1,715	9,333	7,618	5-7	1,715	72
73	Fully Depreciated Assets					5-7		73
74								74
75	TOTALS	\$ 666,932	\$ 12,476	\$ 172,573	\$ 160,097		\$ 590,347	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 4,257,793	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,929	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 260,026	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 160,097	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,225,807	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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?</p> <p><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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	2,984	\$ 184,965	\$	2,984	\$ 184,965	1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs		142	7,121		142	7,121	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a-3	hrs		3,537	186,831		3,537	186,831	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39-2	# of prescripts				151,945		151,945	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>XRAY</u>	39-2					2,204		2,204	12	
13	Other (specify): <u>LAB</u>	39-2					8,452		8,452	13	
14	TOTAL			\$	6,663	\$ 378,917	\$ 162,601	6,663	\$ 541,518	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 **Momence Meadows Nrsing & Reh**

0048033

Report Period Beginning: **01/01/15**

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/15** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (172,072)	\$ (9,294)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,639,960	1,639,960	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,564	103,564	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		65,408	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,571,452	\$ 1,799,638	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		180,000	13
14	Buildings, at Historical Cost		2,839,000	14
15	Leasehold Improvements, at Historical Cost	571,862	571,862	15
16	Equipment, at Historical Cost	239,932	666,932	16
17	Accumulated Depreciation (book methods)	(234,509)	(1,225,807)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	42,364	3,623,379	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(26,128)	(2,831,677)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Replacement Reserve</u>)		139,542	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 593,521	\$ 3,963,231	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,164,973	\$ 5,762,869	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 811,417	\$ 863,951	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,696	38,696	28
29	Short-Term Notes Payable		188,469	29
30	Accrued Salaries Payable	80,808	80,808	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,623	12,623	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		19,578	33
34	Deferred Compensation	55	55	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Working Capital</u>	550,665	550,665	36
37	<u>Working Capital</u>	2,267,183	2,267,183	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,761,447	\$ 4,022,028	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	500,000	500,000	39
40	Mortgage Payable		5,774,341	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>IRS Audit Adjustment</u>		125,101	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 500,000	\$ 6,399,442	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,261,447	\$ 10,421,470	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,096,474)	\$ (4,658,601)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,164,973	\$ 5,762,869	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,894,457)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,894,457)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(202,017)	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)	\$ (202,017)	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)	\$ (2,096,474)	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,104,014	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,104,014	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	328,759	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 328,759	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	44,576	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,457	19
20	Radiology and X-Ray	82	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 47,115	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	943	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 943	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue</u>	25,147	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,147	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,505,978	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	911,913	31
32	Health Care	2,522,417	32
33	General Administration	1,336,303	33
B. Capital Expense			
34	Ownership	1,408,022	34
C. Ancillary Expense			
35	Special Cost Centers	162,601	35
36	Provider Participation Fee	255,430	36
D. Other Expenses (specify):			
37	<u>Bad Debt Exp</u>	110,000	37
38	<u>Medically Necessary Transportation</u>	1,312	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,707,998	40
41	Income before Income Taxes (line 30 minus line 40)**	(202,020)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (202,020)	43
III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,936,337	44
45	Private Pay - Net Inpatient Revenue	57,714	45
46	Medicare - Net Inpatient Revenue	678,135	46
47	Other-(specify) <u>Net Inpatient Revenue</u>	431,828	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,104,014	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Momence Meadows Nrsing & Reh

0048033

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,489	2,826	\$ 107,884	\$ 38.18	1
2	Assistant Director of Nursing	4,114	4,666	149,435	32.03	2
3	Registered Nurses	8,574	10,903	313,641	28.77	3
4	Licensed Practical Nurses	12,796	16,648	418,796	25.16	4
5	CNAs & Orderlies	49,221	56,950	638,197	11.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	6,994	7,626	82,019	10.76	9
10	Activity Assistants					10
11	Social Service Workers	1,745	1,945	36,160	18.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,243	15,866	180,330	11.37	15
16	Dishwashers					16
17	Maintenance Workers	2,066	2,140	32,428	15.15	17
18	Housekeepers	14,029	15,538	159,462	10.26	18
19	Laundry	5,035	5,542	57,404	10.36	19
20	Administrator	1,763	1,955	87,756	44.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,580	10,532	144,958	13.76	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	1,896	2,101	32,276	15.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,545	155,238	\$ 2,440,746 *	\$ 15.72	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	193	\$ 6,741	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	161	5,628	10-3	38
39	Pharmacist Consultant	186	9,324	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	245	12,250	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	40	1,404	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	825	\$ 35,347		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Tara Holmes	Administrator		\$ 23,471	Workers' Compensation Insurance	\$ 109,759	IDPH License Fee	\$ 1,990		
Jordan LaQuanta	Administrator		64,285	Unemployment Compensation Insurance	154,684	Advertising: Employee Recruitment			
				FICA Taxes	208,885	Health Care Worker Background Check			
				Employee Health Insurance	155,959	(Indicate # of checks performed)			
				Employee Meals		Infinity Healthcare	(100)		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	(2,577)		
				pension exp	30,841	IHCA	487		
				employee expenses	3,851	SEIU	1,343		
				uniforms	8,108	Kankakee County Health Department	350		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 87,756						
B. Administrative - Other									
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Bradley Associates	Accounting		\$ 12,619				Out-of-State Travel	\$	
Johnson, Goldberg, & Brown	Accounting		2,500						
Infinity	Accounting		201						
Thompson Hall Santi Cerny	Legal		8,906				In-State Travel		
Stone, Pogrund, and Korey	Legal		68				auto allowance	2,186	
Meyer Magence	Legal		250				mileage	3,238	
Secretary of State	Legal		275				continuing education	1,035	
Dr. Nashib Hashmi	Professional		3,000				Seminar Expense		
MTS Consulting	Professional		2,063						
Infinity Healthcare	Professional/Mgmt		306,107						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 335,989	TOTAL		\$	Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 6,459	

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Momence Meadows Nrsing & Reh

0048033

Report Period Beginning:

01/01/15

Ending:

12/31/15

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Illinois Council on Long Term Care
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,015 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 255,430
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (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? NO 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. \$ 0 Has any meal income been offset against related costs? N/A 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? 0%
- 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? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.