



Facility Name &amp; ID Number Momence Meadows Nrsing &amp; Reh

# 0048033 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	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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	23,035	520	3,571	27,126	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,035	520	3,571	27,126	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.08%

D. How many bed reserve days during this year were paid by the Department? 0 (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 07/01/06

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 1,263

Medicare Intermediary National Government Services

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/17 Fiscal Year: 12/31/17  
\* All facilities other than governmental must report on the accrual basis

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
<b>A. General Services</b>										
1 Dietary	175,963	15,876	6,971	198,810		198,810	(1,201)	197,609		1
2 Food Purchase		157,310		157,310		157,310	1,236	158,546		2
3 Housekeeping	119,688	25,043		144,731		144,731	374	145,105		3
4 Laundry	60,638	8,831		69,469		69,469		69,469		4
5 Heat and Other Utilities			135,043	135,043		135,043	504	135,547		5
6 Maintenance	54,478	16,042	26,320	96,840		96,840	425	97,265		6
7 Other (specify):*										7
<b>8 TOTAL General Services</b>	<b>410,767</b>	<b>223,102</b>	<b>168,334</b>	<b>802,203</b>		<b>802,203</b>	<b>1,338</b>	<b>803,541</b>		<b>8</b>
<b>B. Health Care and Programs</b>										
9 Medical Director			24,004	24,004		24,004		24,004		9
10 Nursing and Medical Records	1,465,542	95,456	51,457	1,612,455		1,612,455	(8,909)	1,603,546		10
10a Therapy			341,257	341,257		341,257		341,257		10a
11 Activities	88,749	12,316		101,065		101,065		101,065		11
12 Social Services	43,950		2,935	46,885		46,885		46,885		12
13 CNA Training										13
14 Program Transportation										14
15 Other (specify):* Pharmacy Consultant			8,010	8,010		8,010	(147)	7,863		15
<b>16 TOTAL Health Care and Programs</b>	<b>1,598,241</b>	<b>107,772</b>	<b>427,663</b>	<b>2,133,676</b>		<b>2,133,676</b>	<b>(9,056)</b>	<b>2,124,620</b>		<b>16</b>
<b>C. General Administration</b>										
17 Administrative	103,147			103,147		103,147		103,147		17
18 Directors Fees										18
19 Professional Services			467,347	467,347		467,347	(163,899)	303,448		19
20 Dues, Fees, Subscriptions & Promotions			10,625	10,625		10,625	191	10,816		20
21 Clerical & General Office Expenses	176,531	37,426	87,380	301,337		301,337	105,752	407,089		21
22 Employee Benefits & Payroll Taxes			796,198	796,198		796,198	29,628	825,826		22
23 Inservice Training & Education										23
24 Travel and Seminar			7,106	7,106		7,106	3,621	10,727		24
25 Other Admin. Staff Transportation										25
26 Insurance-Prop.Liab.Malpractice			243,355	243,355		243,355	37,366	280,721		26
27 Other (specify):*										27
<b>28 TOTAL General Administration</b>	<b>279,678</b>	<b>37,426</b>	<b>1,612,011</b>	<b>1,929,115</b>		<b>1,929,115</b>	<b>12,659</b>	<b>1,941,774</b>		<b>28</b>
<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,288,686</b>	<b>368,300</b>	<b>2,208,008</b>	<b>4,864,994</b>		<b>4,864,994</b>	<b>4,941</b>	<b>4,869,935</b>		<b>29</b>

\*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.

## 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
30	D. Ownership										
	Depreciation			38,454	38,454		38,454	189,600	228,054		30
31	Amortization of Pre-Op. & Org.							238,735	238,735		31
32	Interest			108,024	108,024		108,024	207,477	315,501		32
33	Real Estate Taxes							86,830	86,830		33
34	Rent-Facility & Grounds			1,038,000	1,038,000		1,038,000	(1,033,195)	4,805		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,184,478	1,184,478		1,184,478	(310,553)	873,925		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		66,932		66,932		66,932	(1,213)	65,719		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			231,046	231,046		231,046		231,046		42
43	Other (specify):* <b>Bad Debt</b>			115,018	115,018		115,018	(115,018)			43
44	<b>TOTAL Special Cost Centers</b>		66,932	346,064	412,996		412,996	(116,231)	296,765		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,288,686	435,232	3,738,550	6,462,468		6,462,468	(421,843)	6,040,625		45

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

**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	116,671	30	9
10	Interest and Other Investment Income	(7,901)	32	10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax	(15)	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			18
19	Entertainment			19
20	Contributions	(7,142)	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	(115,018)	43	24
25	Fund Raising, Advertising and Promotional	(8,838)	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	(2,915)	various	29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (25,158)</b>		<b>30</b>

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)	(396,685)	Various
35	Other- Attach Schedule		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (396,685)</b>	<b>36</b>
	(sum of SUBTOTALS		
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (421,843)</b>	<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

Momence Meadows Nrsing & Reh

ID# 0048033

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (1,061)	21	1
2	Lobbying Expenses	(462)	20	2
3	RP Profit	(32)	10	3
4	RP Profit	(147)	15	4
5	RP Profit	(1,213)	39	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	<b>Total</b>	(2,915)		49

Facility Name &amp; ID Number Momence Meadows Nrsing &amp; Reh

# 0048033

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 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)	
1	Dietary	(15)	(1,186)	0	0	0	0	0	0	0	0	0	(1,201)	1
2	Food Purchase	0	1,236	0	0	0	0	0	0	0	0	0	1,236	2
3	Housekeeping	0	374	0	0	0	0	0	0	0	0	0	374	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	504	0	0	0	0	0	0	0	0	0	504	5
6	Maintenance	0	425	0	0	0	0	0	0	0	0	0	425	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(15)</b>	<b>1,353</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,338</b>	<b>8</b>
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(32)	(8,877)	0	0	0	0	0	0	0	0	0	(8,909)	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):*	(147)	0	0	0	0	0	0	0	0	0	0	(147)	15
16	<b>TOTAL Health Care and Program</b>	<b>(179)</b>	<b>(8,877)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(9,056)</b>	<b>16</b>
<b>C. General Administration</b>														
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(167,599)	3,700	0	0	0	0	0	0	0	0	(163,899)	19
20	Fees, Subscriptions & Promotions	(462)	653	0	0	0	0	0	0	0	0	0	191	20
21	Clerical & General Office Expenses	(17,041)	122,486	307	0	0	0	0	0	0	0	0	105,752	21
22	Employee Benefits & Payroll Taxes	0	29,628	0	0	0	0	0	0	0	0	0	29,628	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,621	0	0	0	0	0	0	0	0	0	3,621	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	608	36,758	0	0	0	0	0	0	0	0	37,366	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(17,503)</b>	<b>(10,603)</b>	<b>40,765</b>	<b>0</b>	<b>12,659</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(17,697)</b>	<b>(18,127)</b>	<b>40,765</b>	<b>0</b>	<b>4,941</b>	<b>29</b>							

Facility Name &amp; ID Number Momence Meadows Nrsing &amp; Reh

# 0048033

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 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)
	<b>D. Ownership</b>												
30	Depreciation	116,671	0	72,929	0	0	0	0	0	0	0	0	189,600 30
31	Amortization of Pre-Op. & Org.	0	0	238,735	0	0	0	0	0	0	0	0	238,735 31
32	Interest	(7,901)	0	215,378	0	0	0	0	0	0	0	0	207,477 32
33	Real Estate Taxes	0	0	86,830	0	0	0	0	0	0	0	0	86,830 33
34	Rent-Facility & Grounds	0	0	(1,033,195)	0	0	0	0	0	0	0	0	(1,033,195) 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	<b>TOTAL Ownership</b>	<b>108,770</b>	<b>0</b>	<b>(419,323)</b>	<b>0</b>	<b>(310,553) 37</b>							
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	(1,213)	0	0	0	0	0	0	0	0	0	0	(1,213) 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):*	(115,018)	0	0	0	0	0	0	0	0	0	0	(115,018) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(116,231)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(116,231) 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(25,158)</b>	<b>(18,127)</b>	<b>(378,558)</b>	<b>0</b>	<b>(421,843) 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
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 Nursing & Rehab Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Nursing & 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: 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	
1	V	1 Dietary	\$ 3,587	Infinity Healthcare Management		\$ 2,401	\$ (1,186) 1
2	V	2 Food Purchase		Infinity Healthcare Management		1,236	1,236 2
3	V	3 Housekeeping		Infinity Healthcare Management		374	374 3
4	V	5 Utilities		Infinity Healthcare Management		504	504 4
5	V	6 Maintenance		Infinity Healthcare Management		425	425 5
6	V	10 Nursing	51,457	Infinity Healthcare Management		42,580	(8,877) 6
7	V	11 Activities		Infinity Healthcare Management			
8	V	19 Professional Fees	277,135	Infinity Healthcare Management		109,536	(167,599) 8
9	V	20 Dues, Fees, Subs & Promotions		Infinity Healthcare Management		653	653 9
10	V	21 Clerical & Office Expenses	95,184	Infinity Healthcare Management		217,670	122,486 10
11	V	22 Employee Benefits		Infinity Healthcare Management		29,628	29,628 11
12	V	24 Travel & Seminar		Infinity Healthcare Management		3,621	3,621 12
13	V	26 Insurance		Infinity Healthcare Management		608	608 13
14	Total		\$ 427,363			\$ 409,236	\$ * (18,127) 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	4	5	6	7	8
Schedule V	Line	Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)
15	V 30	Depreciation	\$	Infinity Healthcare Management		\$ 134	\$ 134
16	V 32	Interest		Infinity Healthcare Management		14	14
17	V 34	Rent		Infinity Healthcare Management		4,805	4,805
18	V						
19	V						
20	V 19	Professional Fees		Momence Meadows Realty, LLC		3,700	3,700
21	V 21	Office Expense		Momence Meadows Realty, LLC		307	307
22	V 26	Insurance		Momence Meadows Realty, LLC		36,758	36,758
23	V 30	Depreciation		Momence Meadows Realty, LLC		72,795	72,795
24	V 31	Amortization		Momence Meadows Realty, LLC		238,735	238,735
25	V 32	Interest		Momence Meadows Realty, LLC		215,364	215,364
26	V 33	Property Taxes		Momence Meadows Realty, LLC		86,830	86,830
27	V 34	Rent	1,038,000	Momence Meadows Realty, LLC			(1,038,000)
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,038,000			\$ 659,442	\$ * (378,558)

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

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			Niles Nursing & Rehab Center	Niles				1
2			Oak Lawn Respiratory & Rehab Center	Oak Lawn				2
3			Parker Nursing & Rehab Center	Streator				3
4			Parkshore Estates Nursing & Rehab Ctr	Chicago				4
5			Southpoint Nursing & Rehab Center	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomington				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$				1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	HUD		X	Mortgage	\$35,001.00	8/21/13	\$ 6,360,700	\$ 5,590,255	10/1/36	3.9400	\$ 215,364	1
2												2
3												3
4												4
5												5
<b>Working Capital</b>												
6	Capital One		X	Working Capital	None	8/31/14	26,000,000	5,468,598	8/31/18	various	108,038	6
7												7
8												8
9	<b>TOTAL Facility Related</b>				\$35,001.00		\$ 32,360,700	\$ 11,058,853			\$ 323,402	9
<b>B. Non-Facility Related*</b>												
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 32,360,700	\$ 11,058,853			\$ 323,402	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 31,535 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**

1. Real Estate Tax accrual used on 2016 report.		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>		\$	<b>70,292</b>	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.)		\$	<b>75,527</b>			2
3. Under or (over) accrual (line 2 minus line 1).		\$	5,235			3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>81,595</b>			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.		\$	<b>86,830</b>			7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2012	<u>74,060</u>	8	<b>FOR BHF USE ONLY</b>		
	2013	<u>83,362</u>	9	13	FROM R. E. TAX STATEMENT FOR 2016 \$	13
	2014	<u>85,332</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
	2015	<u>73,616</u>	11	15	LESS REFUND FROM LINE 6 \$	15
	2016	<u>75,527</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

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

**2016 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 2016 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 2016.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-11-19-306-007</u>	<u>Nursing Home</u>	\$ <u>75,527.14</u>	\$ <u>75,527.14</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>75,527.14</u>	\$ <u>75,527.14</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        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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**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.**

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 ground (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))

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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: \_\_\_\_\_

3. Current Period Amortization: 18,023 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:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		7/1/2006	\$ 180,000	1
2					2
3	TOTALS			\$ 180,000	3

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	
Bed(s)*	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		\$ 709,888
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Nurse Call Light	11/30/2006		26,050	668	39	668		8,016
10	A/C on Roof	1/20/2007		420	11	39	11		113
11	A/C on Roof	2/16/2007		4,424	113	39	113		1,189
12	Nurse Call System	5/30/2007		280	7	39	7		75
13	Replace Locks	11/15/2007		7,700	197	39	197		2,071
14	Replace Locks	11/15/2007		104	3	39	3		29
15	Exhaust Vent and Filter	11/27/2007		932	24	39	24		251
16	Shower Remodeling	6/20/2008		3,750	96	39	96		961
17	New Compressor on Walk In Freezer	1/24/2008		2,158	55	39	55		552
18	Sidewalks	3/10/2008		4,289	110	39	110		1,100
19	Asphalt Driveway	4/9/2008		5,775	148	39	148		1,480
20	Asphalt Driveway	4/22/2008		5,775	148	39	148		1,480
21	Shower Room Tiles	4/30/2008		9,483	243	39	243		2,431
22	Drywall, UltraSteel, Concrete, Sand, etc	5/31/2008		1,129	29	39	29		290
23	Mortar	6/8/2008		321	8	39	8		82
24	Grout and Mortar	6/20/2008		83	2	39	2		21
25	Drywall, Mortar and Paint	7/1/2008		523	13	39	13		133
26	Adhesive, Mortar, etc	7/5/2008		597	15	39	15		152
27	Adhesive, Mortar, etc	7/15/2008		126	3	39	3		32
28	Misc Supplies for Shower Remodeling	7/31/2008		61	2	39	2		17
29	Replace Heat Exchanger in Kitchen Roof-Top	12/11/2008		2,936	75	39	75		752
30	Carpet	12/29/2009		4,480	115	39	115		1,034
31	Remodeling (Nurse Station, Ceiling, Lighting, Wallpaper)	2/16/2009		108,504	2,782	39	2,782		25,042
32	Roof Improvements	4/5/2009		3,500	90	39	90		809
33	Roof Improvements	12/21/2009		3,500	90	39	90		809
34	Building & Shower Remodeling w/ Towel Rack	11/2/2010		1,714	44	39	44		352
35	Shower Remodeling & Wall Base Lining	11/17/2010		1,500	38	39	38		306
36	Fire Sprinkler	12/24/2010		1,395	36	39	36		287

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

See Page 12A, Line 70 for total

\*\*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	10
	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		\$ 1,621	37
38	Maintenance, Repairs, Replacements & Wages	11/23/2010	4,485	115	39	115		920	38
39	Materials	12/9/2010	1,482	38	39	38		304	39
40	Materials for Hot Water Valve & Labor	3/30/2010	1,814	47	39	47		373	40
41	Supplies	11/18/2010	1,536	39	39	39		314	41
42	Replace Flame Sensor/Ignitor & Labor	12/1/2010	856	22	39	22		176	42
43	Partial Billing for Cooler Replacement	12/8/2010	2,445	63	39	63		502	43
44	Repatched Walls, Resealed Gravel, Reflashed Drain	3/19/2010	1,650	42	39	42		337	44
45	New Soffit and Installed SPMB Patch	4/12/2010	950	24	39	24		194	45
46	Installed New Shingle Roof & Repaired Rotted Wood	11/22/2010	3,950	101	39	101		809	46
47	Remove Snow, Applied Patch to Roof, Patched 2 Holes	12/27/2010	750	19	39	19		153	47
48	Cabling for New TV Jacks (\$55/jack)	5/24/2010	8,000	205	39	205		1,640	48
49	Repaired Ramp and Asphalt	11/18/2010	2,395	61	39	61		490	49
50	Repair Leaks on Main Water Supply and Dishwasher	6/8/2011	1,297	33	39	33		232	50
51	Replacement of Heat Exchanger	12/2/2010	1,384	35	39	35		247	51
52	Cooler Replacement	12/14/2010	2,445	63	39	63		440	52
53	Heavy Asphalt Coating to Roof	5/23/2011	950	24	39	24		169	53
54	Patching of roof and Replacement of Shingles	10/24/2011	3,000	77	39	77		539	54
55	Retrofit of light fixtures	4/28/2011	16,446	422	39	422		2,953	55
56	Stone/Steel Work and Concrete Replacement	9/1/2011	750	19	39	19		134	56
57	Stone/Steel Work and Concrete Replacement	9/6/2011	750	19	39	19		134	57
58	Replace heat exchanger	11/2/2012	3,775	97	39	97		581	58
59	Replace compressor in freezer	7/6/2012	3,385	87	39	87		521	59
60		7/2/2012	61,769	1,584	39	1,584		9,502	60
61									61
62	2007 Assets not allowed for increased capital reimbursement	2007	3,936	101	39	101		1,059	62
63	2008 Assets not allowed for increased capital reimbursement	2008	3,751	96	39	96		961	63
64	2010 Assets not allowed for increased capital reimbursement	2010	7,000	179	39	179		1,434	64
65	2011 Assets not allowed for increased capital reimbursement	2011	5,078	130	39	130		911	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,194,438	\$ 81,905		\$ 81,905	\$	\$ 787,405	70

\*\*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	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		\$ 3,194,438	\$ 81,905		\$ 81,905		\$ 787,405	1
2	Vinyl tile	8/27/2013	1,373	35	39	35		158	2
3	Heat Exchanger	5/14/2013	2,670	68	39	68		307	3
4	Sprinkler piping & relocating	3/13/2013	48,000	1,231	39	1,231		5,539	4
5	Survey work for sprinkler piping	2/26/2013	3,600	92	39	92		414	5
6	Vinyl tiles - dining room	9/2/2013	1,375	35	39	35		158	6
7	Electrical wiring - dishwasher	12/8/2013	2,375	66	39	66		297	7
8									8
9	3 water heaters removed & new installed	4/4/2014	23,995	616	39	615	(1)	2,463	9
10	Patch wall flashings	5/27/2014	4,850	124	39	124		496	10
11	Nurses station walls / cabinets	5/28/2014	24,900	639	39	638	(1)	2,555	11
12	Patch cords & cables	3/6/2014	2,583	66	39	66		264	12
13	GAF roofing svstem	6/19/2014	63,400	1,628	39	1,626	(2)	6,510	13
14	Replace compressor in "C" wing	7/25/2014	3,373	86	39	86		344	14
15	Rental generator	3/27/2014	9,182	235	39	235		940	15
16	New door for walk-in freezer	8/22/2014	3,046	78	39	78		312	16
17	Kitchen flooring / repair leak	8/29/2014	2,253	58	39	58		232	17
18	Install booster pump	8/29/2014	1,700	44	39	44		176	18
19	Electric repairs in kitchen	8/29/2014	5,975	153	39	153		612	19
20	Kitchen flooring / repair leak	9/2/2014	7,550	194	39	194		776	20
21	Remodel & install tile in 2 rooms & bathroom	10/13/2014	1,620	42	39	42		168	21
22	Remodel & install tile in 2 rooms & bathroom	11/9/2014	2,405	62	39	62		248	22
23									23
24	Heat Exchanger	2/12/2016	3,300	85	39	85		170	24
25	Hot Water Heater for C Wing & Kitchen	8/12/2016	3,045	78	39	78		156	25
26	New Pump & Pipe for Cafeteria	8/3/2016	2,795	72	39	72		144	26
27	Installation of Hot Water Heater	9/15/2016	2,525	65	39	65		130	27
28	Repair Hot Water Heater in D Wing	9/23/2016	2,583	66	39	65	(1)	132	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,425,112	\$ 87,823		\$ 87,818	\$ (5)	\$ 811,106	34

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

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 12B, Carried Forward	\$ 3,425,112	\$ 87,823		\$ 87,818	\$ (5)	\$ 811,106		1
2	Replace Rooftop Unit Heat Exchanger (Hallway)	12/29/2016 3,975	51	39	51		51		2
3	Replace Rooftop Unit Heat Exchanger (Common Area)	1/5/2017 3,760	48	39	48		48		3
4	100 Gallon Hot Water Heater	2/1/2017 2,850	37	39	37		37		4
5	Replace Water Heater	5/1/2017 2,995	38	39	38		38		5
6	Replace Fire Alarm System	11/14/2017 6,349	81	39	81		81		6
7	Replace Fire Alarm Control Panel	11/14/2017 10,196	131	39	131		131		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)	\$ 3,455,237	\$ 88,209		\$ 88,204	\$ (5)	\$ 811,492		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	\$ 696,348	\$ 22,967	\$ 139,270	\$ 116,303	5	\$ 632,743	71
72	Current Year Purchases	2,898	207	580	373	5	207	72
73	Fully Depreciated Assets					5		73
74						5		74
75	<b>TOTALS</b>	\$ 699,246	\$ 23,174	\$ 139,850	\$ 116,676		\$ 632,950	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 4,334,483	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 111,383	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 228,054	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 116,671	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,444,442	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	<b>TOTALS</b>	\$	\$	\$	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?  YES  NO  
 If NO, see instructions.

	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	<b>TOTAL</b>			\$			<b>7</b>

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>	\$ _____
13. <u>2019</u>	\$ _____
14. <u>2020</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: \$ \_\_\_\_\_ 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	<b>TOTAL</b>		\$	\$	<b>21</b>

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	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 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.)

1	Service	Schedule V Line & Column Reference	2 Staff		5 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	2,795	\$ 188,682	\$	2,795	\$ 188,682	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		46	2,522		46	2,522	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,006	150,054		3,006	150,054	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				66,071		66,071	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): XRAY & LAB	39-2					861		861	12
13	Other (specify):									13
14	TOTAL			\$	5,847	\$ 341,258	\$ 66,932	5,847	\$ 408,190	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.

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	\$ (149,800)	\$ 102,405	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,695,991	1,695,991	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	190,215	190,215	6
7	Other Prepaid Expenses	2,070	2,070	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		34,945	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,738,476	\$ 2,025,626	10
<b>B. Long-Term Assets</b>				
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	616,236	616,236	15
16	Equipment, at Historical Cost	282,152	709,152	16
17	Accumulated Depreciation (book methods)	(307,552)	(1,444,440)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	135,438	3,716,453	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(28,653)	(3,311,672)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <b>Replacement Reserve</b> )		228,880	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 697,621	\$ 3,533,609	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,436,097	\$ 5,559,235	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 548,552	\$ 616,667	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,458	36,458	28
29	Short-Term Notes Payable		207,417	29
30	Accrued Salaries Payable	76,069	76,069	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,442	8,442	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		17,656	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>Working Capital</b>	5,468,598	5,468,598	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 6,138,119	\$ 6,431,307	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,382,838	40
41	Bonds Payable			41
42	Deferred Compensation		(2,928,656)	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>	\$	\$ 2,454,182	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,138,119	\$ 8,885,489	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,702,022)	\$ (3,326,254)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,436,097	\$ 5,559,235	48

\*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,988,381)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,988,381)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(713,641)	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)	\$ (713,641)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (3,702,022)	24 *

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

Facility Name &amp; ID Number Momence Meadows Nrsing &amp; Reh

# 0048033

Report Period Beginning: 01/01/17

Ending: 12/31/17

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached

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

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,025,588	1
2	Discounts and Allowances for all Levels	424,085	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,449,673	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	243,181	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 243,181	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	43,153	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,403	19
20	Radiology and X-Ray	737	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 47,293	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	7,620	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,620	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<b>Miscellaneous Revenue</b>	1,061	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,061	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,748,828	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	802,204	31
32	Health Care	2,133,677	32
33	General Administration	1,929,114	33
<b>B. Capital Expense</b>			
34	Ownership	1,184,478	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	66,932	35
36	Provider Participation Fee	231,046	36
<b>D. Other Expenses (specify):</b>			
37	Bad Debt Expense	115,018	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,462,469	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(713,641)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (713,641)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 4,237,085	44
45	Private Pay - Net Inpatient Revenue	103,830	45
46	Medicare - Net Inpatient Revenue	663,720	46
47	Other-(specify)	445,038	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,449,673	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.

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	2,118	2,264	\$ 92,067	\$ 40.67	1	
2	2,945	3,177	107,877	33.96	2	
3	4,380	5,114	166,389	32.54	3	
4	15,869	17,223	508,616	29.53	4	
5	38,973	43,153	559,498	12.97	5	
6					6	
7					7	
8					8	
9	6,667	7,621	88,749	11.65	9	
10					10	
11	1,954	2,195	43,950	20.02	11	
12					12	
13					13	
14					14	
15	13,163	14,446	175,965	12.18	15	
16					16	
17	3,601	3,949	54,478	13.80	17	
18	9,990	10,674	119,689	11.21	18	
19	4,882	5,343	60,638	11.35	19	
20	1,767	2,166	103,147	47.62	20	
21					21	
22					22	
23					23	
24	12,319	13,367	176,531	13.21	24	
25					25	
26					26	
27					27	
28					28	
29					29	
30					30	
31	1,900	2,043	26,929	13.18	31	
32					32	
33	ADMISSION CO	213	234	4,162	17.79	33
34	TOTAL (lines 1 - 33)	120,741	132,969	\$ 2,288,685 *	\$ 17.21	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	199	\$ 6,971	1-3	35
36				36
37				37
38	1,470	51,457	10-3	38
39	160	8,010	15-3	39
40				40
41				41
42				42
43				43
44				44
45	72	2,535	12-3	45
46				46
47				47
48				48
49	TOTAL (lines 35 - 48)	1,901 \$ 68,973		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
A. Administrative Salaries				Description		Description		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sheila Storey			\$ 6,278	Workers' Compensation Insurance	\$ 124,305	IDPH License Fee	\$	
Bibiana Ulrich			96,869	Unemployment Compensation Insurance	42,912	Advertising: Employee Recruitment		
				FICA Taxes	162,889	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	411,178	HO Licenses & Permits	653	
				Employee Meals		IHCA	462	
				Illinois Municipal Retirement Fund (IMRF)*		IHCA PAC	7,418	
				Pension Expense	29,924	IDPH License	1,910	
				Employee Expenses	6,030	Momence Chamber of Commerce	485	
				Uniform Expense	(1,280)	Kankakee County Health Department	350	
				Work Comp Settlement	47,924	Less: Public Relations Expense	( )	
				Employee Background Checks	1,944	Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 103,147				\$ 825,826		\$ 11,278		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description	Line #	Amount	Description	Amount
							Out-of-State Travel	\$
							In-State Travel	
							mileage	6,510
							continuing education	596
							Home Office Travel	3,621
							Seminar Expense	
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 467,347				\$			\$ 10,727	

\* Attach copy of IMRF notifications

\*\*See instructions.

XX. GENERAL INFORMATION:

# 0048033

Report Period Beginning:

01/01/17

Ending:

12/31/17

- (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 of Long Term Care 7418
- (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. \$ 39,213 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. \$ 231,046  
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.