FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0048033

Facility Name: MOMENCE MEADOWS NRSG & REH

Address: 500 S WALNUT ST (Number) MOMENCE (City) 60954 (Zip Code)

County: KANKAKEE

Telephone Number: (815) 472-2423 **Fax #** 815-472-6212

HFS ID Number:

Date of Initial License for Current Owners: 7/1/06

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Alan Sorscher **Telephone Number:** (708) 449-1900
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Alan Sorscher
(Title) CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	140	Skilled (SNF)	140	51,240	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	51,240	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,409	687	4,913	36,009	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,409	687	4,913	36,009	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.28%

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 [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 07/01/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 07/01/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 140 and days of care provided 4,446

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

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

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

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	179,669	24,565	15,000	219,234		219,234	(7,424)	211,810			1
2	Food Purchase		183,639		183,639		183,639	(560)	183,079			2
3	Housekeeping	143,622	21,951		165,573		165,573		165,573			3
4	Laundry	79,272	19,738		99,010		99,010		99,010			4
5	Heat and Other Utilities			138,860	138,860		138,860	565	139,425			5
6	Maintenance	32,744	11,250	52,092	96,086		96,086	365	96,451			6
7	Other (specify):*											7
8	**TOTAL General Services**	435,307	261,143	205,952	902,402		902,402	(7,054)	895,348			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	2,015,819	211,433	31,550	2,258,802		2,258,802	7,551	2,266,353			10
10a	Therapy			424,582	424,582		424,582		424,582			10a
11	Activities	79,711	14,533		94,244		94,244		94,244			11
12	Social Services	50,595		8,958	59,553		59,553		59,553			12
13	CNA Training											13
14	Program Transportation			3,658	3,658		3,658		3,658			14
15	Other (specify):* **Pharmacy Consultant**			10,764	10,764		10,764		10,764			15
16	**TOTAL Health Care and Programs**	2,146,125	225,966	487,912	2,860,003		2,860,003	7,551	2,867,554			16
	C. General Administration											
17	Administrative	73,338			73,338		73,338		73,338			17
18	Directors Fees											18
19	Professional Services			259,030	259,030		259,030	(237,561)	21,469			19
20	Dues, Fees, Subscriptions & Promotions			7,754	7,754		7,754	250	8,004			20
21	Clerical & General Office Expenses	158,207	59,451	26,030	243,688		243,688	35,772	279,460			21
22	Employee Benefits & Payroll Taxes			573,250	573,250		573,250	61,798	635,048			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,074	11,074		11,074	231	11,305			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			117,878	117,878		117,878	31,306	149,184			26
27	Other (specify):*											27
28	**TOTAL General Administration**	231,545	59,451	995,016	1,286,012		1,286,012	(108,204)	1,177,808			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,812,977	546,560	1,688,880	5,048,417		5,048,417	(107,707)	4,940,710			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 NRSG & REH #0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			17,782	17,782		17,782	65,271	83,053			30
31	Amortization of Pre-Op. & Org.			2,825	2,825		2,825	324,540	327,365			31
32	Interest			196,968	196,968		196,968	357,190	554,158			32
33	Real Estate Taxes							42,004	42,004			33
34	Rent-Facility & Grounds			1,038,000	1,038,000		1,038,000	(1,032,081)	5,919			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			5,861	5,861		5,861		5,861			36
37	TOTAL Ownership			1,261,436	1,261,436		1,261,436	(243,076)	1,018,360			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		258,119		258,119		258,119		258,119			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			441,437	441,437		441,437		441,437			42
43	Other (specify):* Bad Debt			1,145,000	1,145,000		1,145,000		1,145,000			43
44	TOTAL Special Cost Centers		258,119	1,586,437	1,844,556		1,844,556		1,844,556			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,812,977	804,679	4,536,753	8,154,409		8,154,409	(350,783)	7,803,626			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 NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,414	30		9
10	Interest and Other Investment Income	(1,257)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(22,264)	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	(8,527)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (26,644)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(324,139)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (324,139)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (350,783)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MOMENCE MEADOWS NRSG & REH

ID# 0048033

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	misc inc-prior year	$ (8,527)	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**	(8,527)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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)	
	A. General Services													
1	Dietary	(10)	(7,414)	0	0	0	0	0	0	0	0	0	(7,424)	1
2	Food Purchase	0	(560)	0	0	0	0	0	0	0	0	0	(560)	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	565	0	0	0	0	0	0	0	0	0	565	5
6	Maintenance	0	365	0	0	0	0	0	0	0	0	0	365	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10)	(7,044)	0	0	0	0	0	0	0	0	0	(7,054)	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	7,551	0	0	0	0	0	0	0	0	0	7,551	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	7,551	0	0	0	0	0	0	0	0	0	7,551	16
	C. General Administration													
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	(237,561)	0	0	0	0	0	0	0	0	0	(237,561)	19
20	Fees, Subscriptions & Promotions	0	0	250	0	0	0	0	0	0	0	0	250	20
21	Clerical & General Office Expenses	(30,791)	66,543	20	0	0	0	0	0	0	0	0	35,772	21
22	Employee Benefits & Payroll Taxes	0	61,798	0	0	0	0	0	0	0	0	0	61,798	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	231	0	0	0	0	0	0	0	0	0	231	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	384	30,922	0	0	0	0	0	0	0	0	31,306	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(30,791)	(108,605)	31,192	0	0	0	0	0	0	0	0	(108,204)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,801)	(108,098)	31,192	0	0	0	0	0	0	0	0	(107,707)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense D. Ownership	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)	
30	Depreciation	5,414	145	59,712	0	0	0	0	0	0	0	0	65,271	30
31	Amortization of Pre-Op. & Org.	0	0	324,540	0	0	0	0	0	0	0	0	324,540	31
32	Interest	(1,257)	0	358,447	0	0	0	0	0	0	0	0	357,190	32
33	Real Estate Taxes	0	0	42,004	0	0	0	0	0	0	0	0	42,004	33
34	Rent-Facility & Grounds	0	5,919	(1,038,000)	0	0	0	0	0	0	0	0	(1,032,081)	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**	4,157	6,064	(253,297)	0	0	0	0	0	0	0	0	(243,076)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,644)	(102,034)	(222,105)	0	0	0	0	0	0	0	0	(350,783)	45

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	31.58%			Infinity Healthcare	Hillside, Il	management co
Moishe Gubin	33.68%					
Bernard Steinberg	3.16%					
A & F General Partnership	31.58%					

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. [x] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	dietary	$ 16,250	Infinity Healthcare Management		$ 8,836	$ (7,414)	1
2	V	2	food	560	Infinity Healthcare Management			(560)	2
3	V	5	utilities		Infinity Healthcare Management		565	565	3
4	V	6	maint	3,200	Infinity Healthcare Management		3,565	365	4
5	V	10	nursing	27,300	Infinity Healthcare Management		34,851	7,551	5
6	V	19	prof svcs	247,000	Infinity Healthcare Management		939	(246,061)	6
7	V	21	office exp	12,807	Infinity Healthcare Management		79,350	66,543	7
8	V	22	employee benefits	4,466	Infinity Healthcare Management		66,264	61,798	8
9	V	24	travel		Infinity Healthcare Management		231	231	9
10	V	26	insurance		Infinity Healthcare Management		384	384	10
11	V	30	depreciation		Infinity Healthcare Management		145	145	11
12	V	34	rent		Infinity Healthcare Management		5,919	5,919	12
13	V	19	prof svcs		Momence Meadows Realty LLC		8,500	8,500	13
14	Total			$ 311,583			$ 209,549	$ * (102,034)	14

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

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. [x] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	filing fees	$	Momence Meadows Realty LLC		$ 250	$ 250	15
16	V	21	Office Expenses		Momence Meadows Realty LLC		20	20	16
17	V	26	Insurance		Momence Meadows Realty LLC		30,922	30,922	17
18	V	30	Depreciation		Momence Meadows Realty LLC		59,712	59,712	18
19	V	31	Amortization		Momence Meadows Realty LLC		324,540	324,540	19
20	V	32	Interest	11,110	Momence Meadows Realty LLC		369,557	358,447	20
21	V	33	Property Taxes		Momence Meadows Realty LLC		42,004	42,004	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			$ 1,049,110			$ 827,005	$ * (222,105)	39

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

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 [x]

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

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

	1 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	TOTALS					$	$		$	25

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Prudential		x	HUD Mortgage	$39,328.00	7/25/01	$ 6,526,000	$ 6,031,814	7/25/36	5.9000	$ 359,587	1
2												2
3												3
4												4
5												5
	Working Capital											
6	first merit bank		x	working capital	none	7/11/06	1,700,000	1,055,000	3/7/13	various	196,968	6
7												7
8												8
9	TOTAL Facility Related				$39,328.00		$ 8,226,000	$ 7,086,814			$ 556,555	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,226,000	$ 7,086,814			$ 556,555	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** **n/a** **Line #** _____

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

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

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 41,764	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.)		$ 45,089	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,325	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,679	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.		$ 42,004	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	62,998	8
	2008	41,265	9
	2009	41,764	10
	2010	42,004	11
	2011	45,089	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MOMENCE MEADOWS NRSG & REH COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0048033

CONTACT PERSON REGARDING THIS REPORT Alan Sorscher

TELEPHONE 708-449-1900 FAX #:

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-11-19-306-007	Nursing Home	$ 45,088.88	$ 45,088.88
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,088.88	$ 45,088.88

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

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

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 [x] (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 [x] (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).

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: 4,640,039
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 327,365
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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	nursing home		7/1/2006	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140		2006		$ 2,000,000	$ 51,288	39	$ 51,282	$ (6)	$ 333,345	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse Call Light			11/30/2006	26,050	668	39	668		4,676	9
10	A/C on Roof			1/20/2007	420	11	39	11		73	10
11	A/C on Roof			2/16/2007	4,424	113	39	113		768	11
12	Nurse Call System			5/30/2007	280	7	39	7		49	12
13	Replace Locks			11/15/2007	7,700	197	39	197		1,337	13
14	Replace Locks			11/15/2007	104	3	39	3		18	14
15	Exhaust Vent and Filter			11/27/2007	932	24	39	24		162	15
16	Shower Remodeling			6/20/2008	3,750	96	39	96		520	16
17	New Compressor on Walk In Freezer			1/24/2008	2,158	55	39	55		299	17
18	Sidewalks			3/10/2008	4,289	110	39	110		594	18
19	Asphalt Driveway			4/9/2008	5,775	148	39	148		800	19
20	Asphalt Driveway			4/22/2008	5,775	148	39	148		800	20
21	Shower Room Tiles			4/30/2008	9,483	243	39	243		1,314	21
22	Drywall, Ultrasteel, Concrete, Sand, etc			5/31/2008	1,129	29	39	29		156	22
23	Mortar			6/8/2008	321	8	39	8		44	23
24	Grout and Mortar			6/20/2008	83	2	39	2		12	24
25	Drywall, Mortar and Paint			7/1/2008	523	13	39	13		72	25
26	Adhesive, Mortar, etc			7/5/2008	597	15	39	15		83	26
27	Adhesive, Mortar, etc			7/15/2008	126	3	39	3		17	27
28	Misc Supplies for Shower Remodeling			7/31/2008	61	2	39	2		8	28
29	Replace Heat Exchanger in Kitchen Roof-Top			12/11/2008	2,936	75	39	75		407	29
30	Carpet			12/29/2009	4,480	115	39	115		460	30
31	Remodeling (Nurse Station, Ceiling, Lighting, Wallpaper)			2/16/2009	108,504	3,158	39	3,158		11,506	31
32	Roof Improvements			4/5/2009	3,500	90	39	90		359	32
33	Roof Improvements			12/21/2009	3,500	90	39	90		359	33
34	Building & Shower Remodeling w/ Towel Rack			11/2/2010	1,714	44	39	44		146	34
35	Shower Remodeling & Wall Base Lining			11/17/2010	1,500	38	39	38		128	35
36	Fire Sprinkler			12/24/2010	1,395	36	39	36		119	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 NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Paint, Materials, and Wall Repairs	11/23/2010	$ 7,900	$ 203	39	$ 203	$	$ 674	37
38	Maintenance, Repairs, Replacements & Wages	11/23/2010	4,485	115	39	115		383	38
39	Materials	12/9/2010	1,482	38	39	38		126	39
40	Materials for Hot Water Valve & Labor	3/30/2010	1,814	47	39	47		155	40
41	Supplies	11/18/2010	1,536	39	39	39		131	41
42	Replace Flame Sensor/Ignitor & Labor	12/1/2010	856	22	39	22		73	42
43	Partial Billing for Cooler Replacement	12/8/2010	2,445	63	39	63		209	43
44	Repatched Walls, Resealed Gravel, Reflashed Drain	3/19/2010	1,650	42	39	42		141	44
45	New Soffit and Installed SPMB Patch	4/12/2010	950	24	39	24		81	45
46	Installed New Shingle Roof & Repaired Rotted Wood	11/22/2010	3,950	101	39	101		337	46
47	Remove Snow, Applied Patch to Roof, Patched 2 Holes	12/27/2010	750	19	39	19		64	47
48	Cabling for New TV Jacks ($55/jack)	5/24/2010	8,000	205	39	205		682	48
49	Repaired Ramp and Asphalt	11/18/2010	2,395	61	39	61		204	49
50	Repair Leaks on Main Water Supply and Dishwasher	6/8/2011	1,297	39	39	33	(6)	79	50
51	Replacement of Heat Exchanger	12/2/2010	1,384	42	39	35	(7)	84	51
52	Cooler Replacement	12/14/2010	2,445	75	39	63	(12)	149	52
53	Heavy Asphalt Coating to Roof	5/23/2011	950	29	39	24	(5)	58	53
54	Patching of roof and Replacement of Shingles	10/24/2011	3,000	91	39	77	(14)	183	54
55	Retrofit of light fixtures	4/28/2011	16,446	501	39	422	(79)	1,002	55
56	Stone/Steel Work and Concrete Replacement	9/1/2011	750	23	39	19	(4)	46	56
57	Stone/Steel Work and Concrete Replacement	9/6/2011	750	23	39	19	(4)	46	57
58	Replace heat exchanger	11/2/2012	3,775	97	39	16	(81)	97	58
59	Replace compressor in freezer	7/6/2012	3,385	87	39	43	(44)	87	59
60		7/2/2012	61,769	1,584	39	792	(792)	1,584	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,335,671	$ 60,401		$ 59,348	$ (1,052)	$ 365,306	70

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

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 119,759	$ 14,738	$ 21,165	$ 6,427	various	$ 97,743	71
72	Current Year Purchases	24,551	2,355	2,540	185	various	2,355	72
73	Fully Depreciated Assets	54,632				various	54,632	73
74								74
75	TOTALS	$ 198,942	$ 17,093	$ 23,705	$ 6,612		$ 154,730	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)	$ 2,634,613	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 77,494	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,053	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,560	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 520,036	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
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

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: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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.

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 238,013	$		$ 238,013	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			5,800			5,800	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			180,769			180,769	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 prescrpts				237,448		237,448	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): lab & radiology	39-2					20,671		20,671	12
13	Other (specify):									13
14	TOTAL			$		$ 424,582	$ 258,119		$ 682,701	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.

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 143,190	$ 248,976	1
2	Cash-Patient Deposits	(8,253)	(8,253)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,841,962	2,972,408	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	245,575	245,575	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,222,474	$ 3,458,706	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		2,000,000	14
15	Leasehold Improvements, at Historical Cost	355,437	355,437	15
16	Equipment, at Historical Cost	129,006	188,006	16
17	Accumulated Depreciation (book methods)	(131,537)	(519,660)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	42,364	312,704	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(17,653)	(134,804)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		2,523,838	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 377,617	$ 4,825,521	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,600,091	$ 8,284,227	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 942,838	$ 942,838	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	331,327	331,327	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		62,824	32
33	Accrued Interest Payable		1,243	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	working capital	1,055,000	1,055,000	36
37	Related Party payable	2,382,416	2,382,416	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,711,581	$ 4,775,648	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,031,814	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,031,814	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,711,581	$ 10,807,462	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,111,490)	$ (2,523,235)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,600,091	$ 8,284,227	48

*(See instructions.)

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH **#** 0048033 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 199,480	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 199,480	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,260,970)	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	(50,000)	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)**	$ (1,310,970)	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)**	$ (1,111,490)	24	*

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

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,072,003	1
2	Discounts and Allowances for all Levels	(500,248)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,571,755	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	86,364	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 86,364	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	170,647	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,461	19
20	Radiology and X-Ray	12,428	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 225,536	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,257	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,257	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Revenue	8,527	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,527	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,893,439	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	902,402	31
32	Health Care	2,860,003	32
33	General Administration	1,286,012	33
	B. Capital Expense		
34	Ownership	1,261,436	34
	C. Ancillary Expense		
35	Special Cost Centers	258,119	35
36	Provider Participation Fee	441,437	36
	D. Other Expenses (specify):		
37	bad debt	1,145,000	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,154,409	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,260,970)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,260,970)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,442,439	44
45	Private Pay - Net Inpatient Revenue	14,440	45
46	Medicare - Net Inpatient Revenue	1,999,731	46
47	Other-(specify)	115,145	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,571,755	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 NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,888	2,208	$ 91,113	$ 41.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,015	7,982	272,571	34.15	3
4	Licensed Practical Nurses	31,007	35,627	908,184	25.49	4
5	CNAs & Orderlies	63,544	71,157	717,984	10.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,338	8,244	79,711	9.67	9
10	Activity Assistants					10
11	Social Service Workers	2,320	2,589	50,595	19.54	11
12	Dietician	14,882	16,914	179,669	10.62	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,388	3,804	32,744	8.61	17
18	Housekeepers	11,685	13,129	143,622	10.94	18
19	Laundry	7,622	8,693	79,272	9.12	19
20	Administrator	1,728	1,904	73,338	38.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,704	9,651	158,207	16.39	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	1,828	2,084	25,967	12.46	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,949	183,986	$ 2,812,977 *	$ 15.29	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	429	$ 15,000	8-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	631	31,550	16-3	38
39	Pharmacist Consultant	215	10,764	16-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	256	8,958	13-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,531	$ 66,272		49

C. CONTRACT NURSES

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

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
T'kira Siler	admin		$ 70,588
Dino Varnavos	admin		2,750
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,338

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
bradley & associates	acctg	$ 14,026
johnson goldberg & brown	acctg	2,500
belhaven	acctg	577
ambassador	LOC Fees	6,964
capital one fees	LOC Fees	6,963
infinity healthcare	pro fees	228,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 259,030

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,634
Unemployment Compensation Insurance	46,237
FICA Taxes	203,097
Employee Health Insurance	175,522
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
pension	52,724
uniforms	14,123
employee exp	(12,087)
Infinity Healthcare Employee Benefits	61,798
TOTAL (agree to Schedule V, line 22, col.8)	$ 635,048

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
illinois council	7,007
sec of state	527
clia	150
public health	70
filing fees	250
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,004

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
mileage	4,017
auto exp	6,862
Seminar Expense	
education	195
Infinity Healthcare auto exp	108
Infinity Healthcare travel & entertainment	123
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,305

**See instructions.

Facility Name & ID Number MOMENCE MEADOWS NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
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 NRSG & REH # 0048033 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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? **no**
If YES, give association name and amount. **n/a**

(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. $ **40,187** 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. $ **441,437**
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. n/a
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:

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.