FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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.

I. IDPH License ID Number: 0048033

Facility Name: Momence Meadows Nrsing & Reh

Address: 500 South 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: 07/01/2006

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 01/01/2014 to 12/31/2014 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 Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	51,100	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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,399	438	4,671	34,508	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,399	438	4,671	34,508	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.53%

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 3,409

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	174,741		6,741	181,482		181,482	3,468	184,950			1
2	Food Purchase		235,026		235,026		235,026		235,026			2
3	Housekeeping	156,652	21,962		178,614		178,614		178,614			3
4	Laundry	38,497	14,077		52,574		52,574		52,574			4
5	Heat and Other Utilities			156,487	156,487		156,487	844	157,331			5
6	Maintenance	36,269	39,547	37,747	113,563		113,563	1,846	115,409			6
7	Other (specify):*											7
8	TOTAL General Services	406,159	310,612	200,975	917,746		917,746	6,158	923,904			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,878,955	285,428	9,162	2,173,545		2,173,545	42,824	2,216,369			10
10a	Therapy			426,068	426,068		426,068		426,068			10a
11	Activities	77,977	20,601		98,578		98,578		98,578			11
12	Social Services	36,258		2,559	38,817		38,817		38,817			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* rx consultant			10,233	10,233		10,233		10,233			15
16	TOTAL Health Care and Programs	1,993,190	306,029	456,422	2,755,641		2,755,641	42,824	2,798,465			16
	C. General Administration											
17	Administrative	98,096			98,096		98,096		98,096			17
18	Directors Fees											18
19	Professional Services			255,578	255,578		255,578	(236,707)	18,871			19
20	Dues, Fees, Subscriptions & Promotions			9,267	9,267		9,267		9,267			20
21	Clerical & General Office Expenses	137,492	59,690	22,371	219,553		219,553	112,479	332,032			21
22	Employee Benefits & Payroll Taxes			595,911	595,911		595,911	25,827	621,738			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,158	8,158		8,158	287	8,445			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			311,419	311,419		311,419	842	312,261			26
27	Other (specify):*											27
28	TOTAL General Administration	235,588	59,690	1,202,704	1,497,982		1,497,982	(97,272)	1,400,710			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,634,937	676,331	1,860,101	5,171,369		5,171,369	(48,290)	5,123,079			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Momence Meadows Nrsing & Reh #0048033 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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			86,169	86,169		86,169	30,921	117,090			30
31	Amortization of Pre-Op. & Org.			327,360	327,360		327,360		327,360			31
32	Interest			490,396	490,396		490,396	(3,175)	487,221			32
33	Real Estate Taxes			79,475	79,475		79,475		79,475			33
34	Rent-Facility & Grounds			1,038,000	1,038,000		1,038,000	(1,366,762)	(328,762)			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,021,400	2,021,400		2,021,400	(1,339,016)	682,384			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		160,060		160,060		160,060		160,060			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			265,925	265,925		265,925		265,925			42
43	Other (specify):* **bad debt**			94,510	94,510		94,510	(94,510)				43
44	**TOTAL Special Cost Centers**		160,060	360,435	520,495		520,495	(94,510)	425,985			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,634,937	836,391	4,241,936	7,713,264		7,713,264	(1,481,816)	6,231,448			45

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	30,921	30		9
10	Interest and Other Investment Income	(3,175)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(94,510)	43		24
25	Fund Raising, Advertising and Promotional				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	(1,380,359)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,447,123)		$	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)	(34,693)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (34,693)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,481,816)		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Momence Meadows Nrsing & Reh

ID# **0048033**

Report Period Beginning: **01/01/2014**

Ending: **12/31/2014**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	misc income	$ (359)	21	1
2	rent	(1,380,000)	34	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**	(1,380,359)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Momence Meadows Nrsing & Reh **#** 0048033 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	0	3,468	0	0	0	0	0	0	0	0	0	3,468	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	844	0	0	0	0	0	0	0	0	0	844	5
6	Maintenance	0	1,846	0	0	0	0	0	0	0	0	0	1,846	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	6,158	0	0	0	0	0	0	0	0	0	6,158	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	42,824	0	0	0	0	0	0	0	0	0	42,824	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	42,824	0	0	0	0	0	0	0	0	0	42,824	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	(236,707)	0	0	0	0	0	0	0	0	0	(236,707)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(359)	112,838	0	0	0	0	0	0	0	0	0	112,479	21
22	Employee Benefits & Payroll Taxes	0	25,827	0	0	0	0	0	0	0	0	0	25,827	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	287	0	0	0	0	0	0	0	0	0	287	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	842	0	0	0	0	0	0	0	0	0	842	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(359)	(96,913)	0	0	0	0	0	0	0	0	0	(97,272)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(359)	(47,931)	0	0	0	0	0	0	0	0	0	(48,290)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Momence Meadows Nrsing & Reh **#** 0048033 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	30,921	0	0	0	0	0	0	0	0	0	0	30,921	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,175)	0	0	0	0	0	0	0	0	0	0	(3,175)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,380,000)	13,238	0	0	0	0	0	0	0	0	0	(1,366,762)	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	(1,352,254)	13,238	0	0	0	0	0	0	0	0	0	(1,339,016)	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):*	(94,510)	0	0	0	0	0	0	0	0	0	0	(94,510)	43
44	TOTAL Special Cost Centers	(94,510)	0	0	0	0	0	0	0	0	0	0	(94,510)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,447,123)	(34,693)	0	0	0	0	0	0	0	0	0	(1,481,816)	45

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	31.5%			Infinity Healthcare	Hillside	Mgmt Co
Moishe Gubin	31.5%					
Bernard Steinberg	3.4%					
A & F Realty	31.5%					

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	$ 6,741	Infinity Healthcare Management of Illinois		$ 10,209	$ 3,468	1
2	V	2	food		Infinity Healthcare Management of Illinois				2
3	V	5	utilities		Infinity Healthcare Management of Illinois		844	844	3
4	V	6	maintenance		Infinity Healthcare Management of Illinois		1,846	1,846	4
5	V	10	nursing	5,137	Infinity Healthcare Management of Illinois		47,961	42,824	5
6	V	19	prof fees	242,048	Infinity Healthcare Management of Illinois		5,341	(236,707)	6
7	V	21	office exp	54,845	Infinity Healthcare Management of Illinois		167,683	112,838	7
8	V	22	employee benefits	2,309	Infinity Healthcare Management of Illinois		28,136	25,827	8
9	V	24	travel	304	Infinity Healthcare Management of Illinois		591	287	9
10	V	26	insurance		Infinity Healthcare Management of Illinois		842	842	10
11	V	32	interest		Infinity Healthcare Management of Illinois				11
12	V	34	rent		Infinity Healthcare Management of Illinois		13,238	13,238	12
13	V	19	prof svcs		Infinity Healthcare Management of Illinois				13
14	Total			$ 311,384			$ 276,691	$ * (34,693)	14

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	
						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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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 Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	HUD		x	mortgage	$35,001.00	8/21/13	$ 6,360,700	$ 6,144,004	10/1/36	3.2830	$ 245,814	1
2												2
3												3
4												4
5												5
	Working Capital											
6	capital one		x	working capital	none	08/31/14	26,000,000	534,550	08/31/2018	2.7500	33,144	6
7	infinity funding	a		working capital	none	various	2,735,000	2,235,000	various	various	211,438	7
8												8
9	TOTAL Facility Related				$35,001.00		$ 35,095,700	$ 8,913,554			$ 490,396	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 35,095,700	$ 8,913,554			$ 490,396	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 Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 40,905	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.)		$ 83,362	2
3. Under or (over) accrual (line 2 minus line 1).		$ 42,457	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 37,018	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.		$ 79,475	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009	41,764	8
2010	42,004	9
2011	45,089	10
2012	74,060	11
2013	83,362	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-11-19-306-007	nursing home	$ 83,362.26	$ 83,362.26
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,362.26	$ 83,362.26

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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? [x] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 270,340
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 18,023
4. Dates Incurred: prior to 07/01/2006

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 Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 51,282	39	$ 51,282	$	$ 435,915	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse Call Light			11/30/2006	26,050	668	39	668		6,012	9
10	A/C on Roof			1/20/2007	420	11	39	11		81	10
11	A/C on Roof			2/16/2007	4,424	113	39	113		850	11
12	Nurse Call System			5/30/2007	280	7	39	7		54	12
13	Replace Locks			11/15/2007	7,700	197	39	197		1,480	13
14	Replace Locks			11/15/2007	104	3	39	3		20	14
15	Exhaust Vent and Filter			11/27/2007	932	24	39	24		179	15
16	Shower Remodeling			6/20/2008	3,750	96	39	96		673	16
17	New Compressor on Walk In Freezer			1/24/2008	2,158	55	39	55		387	17
18	Sidewalks			3/10/2008	4,289	110	39	110		770	18
19	Asphalt Driveway			4/9/2008	5,775	148	39	148		1,036	19
20	Asphalt Driveway			4/22/2008	5,775	148	39	148		1,036	20
21	Shower Room Tiles			4/30/2008	9,483	244	39	243	(1)	1,702	21
22	Drywall, Ultrasteel, Concrete, Sand, etc			5/31/2008	1,129	29	39	29		203	22
23	Mortar			6/8/2008	321	8	39	8		58	23
24	Grout and Mortar			6/20/2008	83	2	39	2		15	24
25	Drywall, Mortar and Paint			7/1/2008	523	13	39	13		94	25
26	Adhesive, Mortar, etc			7/5/2008	597	15	39	15		107	26
27	Adhesive, Mortar, etc			7/15/2008	126	3	39	3		23	27
28	Misc Supplies for Shower Remodeling			7/31/2008	61	2	39	2		11	28
29	Replace Heat Exchanger in Kitchen Roof-Top			12/11/2008	2,936	75	39	75		527	29
30	Carpet			12/29/2009	4,480	115	39	115		689	30
31	Remodeling (Nurse Station, Ceiling, Lighting, Wallpaper)			2/16/2009	108,504	2,782	39	2,782		16,696	31
32	Roof Improvements			4/5/2009	3,500	90	39	90		539	32
33	Roof Improvements			12/21/2009	3,500	90	39	90		539	33
34	Building & Shower Remodeling w/ Towel Rack			11/2/2010	1,714	44	39	44		220	34
35	Shower Remodeling & Wall Base Lining			11/17/2010	1,500	38	39	38		192	35
36	Fire Sprinkler			12/24/2010	1,395	36	39	36		179	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$	$ 1,012	37
38	Maintenance, Repairs, Replacements & Wages	11/23/2010	4,485	115	39	115		575	38
39	Materials	12/9/2010	1,482	38	39	38		190	39
40	Materials for Hot Water Valve & Labor	3/30/2010	1,814	47	39	47		232	40
41	Supplies	11/18/2010	1,536	39	39	39		197	41
42	Replace Flame Sensor/Ignitor & Labor	12/1/2010	856	22	39	22		110	42
43	Partial Billing for Cooler Replacement	12/8/2010	2,445	63	39	63		313	43
44	Repatched Walls, Resealed Gravel, Reflashed Drain	3/19/2010	1,650	42	39	42		211	44
45	New Soffit and Installed SPMB Patch	4/12/2010	950	24	39	24		122	45
46	Installed New Shingle Roof & Repaired Rotted Wood	11/22/2010	3,950	101	39	101		506	46
47	Remove Snow, Applied Patch to Roof, Patched 2 Holes	12/27/2010	750	19	39	19		96	47
48	Cabling for New TV Jacks ($55/jack)	5/24/2010	8,000	205	39	205		1,025	48
49	Repaired Ramp and Asphalt	11/18/2010	2,395	61	39	61		307	49
50	Repair Leaks on Main Water Supply and Dishwasher	6/8/2011	1,297	33	39	33		133	50
51	Replacement of Heat Exchanger	12/2/2010	1,384	35	39	35		142	51
52	Cooler Replacement	12/14/2010	2,445	63	39	63		251	52
53	Heavy Asphalt Coating to Roof	5/23/2011	950	24	39	24		97	53
54	Patching of roof and Replacement of Shingles	10/24/2011	3,000	77	39	77		308	54
55	Retrofit of light fixtures	4/28/2011	16,446	423	39	422	(1)	1,687	55
56	Stone/Steel Work and Concrete Replacement	9/1/2011	750	19	39	19		77	56
57	Stone/Steel Work and Concrete Replacement	9/6/2011	750	19	39	19		77	57
58	Replace heat exchanger	11/2/2012	3,775	97	39	97		290	58
59	Replace compressor in freezer	7/6/2012	3,385	87	39	87		260	59
60		7/2/2012	61,769	1,583	39	1,584	1	4,750	60
61									61
62	2007 Assets not allowed for increased capital reimbursement	2007	3,936	101	39	101		756	62
63	2008 Assets not allowed for increased capital reimbursement	2008	3,751	97	39	96	(1)	673	63
64	2010 Assets not allowed for increased capital reimbursement	2010	7,000	180	39	179	(1)	897	64
65	2011 Assets not allowed for increased capital reimbursement	2011	5,078	130	39	130		521	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,355,436	$ 60,395		$ 60,392	$ (3)	$ 486,102	70

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,355,436	$ 60,395		$ 60,392	$ (3)	$ 486,102	1
2	Vinyl tile	8/27/2013	1,373	35	39	35		53	2
3	Heat Exchanger	5/14/2013	2,670	68	39	68		103	3
4	Sprinkler piping & relocating	3/13/2013	48,000	1,231	39	1,231		1,846	4
5	Survey work for sprinkler piping	2/26/2013	3,600	92	39	92		138	5
6	Vinyl tiles - dining room	9/2/2013	1,375	35	39	35		53	6
7	Electrical wiring - dishwasher	12/5/2013	2,575	66	39	66		99	7
8									8
9	3 water heaters removed & new installed	4/4/2014	23,995	615	39	615		615	9
10	Patch wall flashings	5/27/2014	4,850	124	39	124		124	10
11	Nurses station walls / cabinets	5/28/2014	24,900	638	39	638		638	11
12	Patch cords & cables	3/6/2014	2,583	66	39	66		66	12
13	GAF roofing system	6/19/2014	63,400	1,626	39	1,626		1,626	13
14	Replace compressor in "C" wing	7/25/2014	3,373	86	39	86		86	14
15	Rental generator	3/27/2014	9,182	235	39	235		235	15
16	New door for walk-in freezer	8/22/2014	3,046	78	39	78		78	16
17	Kitchen flooring / repair leak	8/29/2014	2,253	58	39	58		58	17
18	Install booster pump	8/29/2014	1,700	44	39	44		44	18
19	Electric repairs in kitchen	8/29/2014	5,975	153	39	153		153	19
20	Kitchen flooring / repair leak	9/2/2014	7,550	194	39	194		194	20
21	Remodel & install tile in 2 rooms & bathroom	10/13/2014	1,620	42	39	42		42	21
22	Remodel & install tile in 2 rooms & bathroom	11/9/2014	2,405	62	39	62		62	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)		$ 2,571,861	$ 65,943		$ 65,940	$ (3)	$ 492,415	34

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 238,451	$ 10,712	$ 47,690	$ 36,978	various	$ 200,361	71
72	Current Year Purchases	17,297	9,514	3,459	(6,055)	5	9,514	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 255,748	$ 20,226	$ 51,150	$ 30,924		$ 209,875	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)	$ 2,927,609	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 86,169	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 117,090	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 30,921	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 702,290	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 Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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.	/2015	$
13.	/2016	$
14.	/2017	$

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 Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$		$ 344,402	$		$ 344,402	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			8,025			8,025	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			73,641			73,641	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				148,162		148,162	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): lab xray amb	39-2					11,898		11,898	12
13	Other (specify):									13
14	TOTAL			$		$ 426,068	$ 160,060		$ 586,128	14

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 74,246	$ 349,617	1
2	Cash-Patient Deposits	(22,216)	(22,216)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,488,941	1,514,660	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	574,195	574,195	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)**	$ 2,115,166	$ 2,416,256	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	571,862	571,862	15
16	Equipment, at Historical Cost	185,812	244,812	16
17	Accumulated Depreciation (book methods)	(207,375)	(702,290)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	42,364	312,704	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(23,303)	(176,501)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		2,075,573	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 569,360	$ 4,426,160	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,684,526	$ 6,842,416	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 919,154	$ 983,221	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	390,279	390,279	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	working capital	2,235,000	2,235,000	36
37	working capital	1,034,550	1,034,550	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,578,983	$ 4,643,050	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,144,004	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)**	$	$ 6,144,004	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,578,983	$ 10,787,054	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,894,457)	$ (3,944,638)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,684,526	$ 6,842,416	48

***(See instructions.)**

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,737,528)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,737,528)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	132,483	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) **related party prop co NI**	(289,412)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (156,929)	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)**	$ (1,894,457)	24	*

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 6,687,797	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,687,797	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	116,416	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 116,416	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,175	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,175	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**related party prop con income**	1,038,000	28
28a	**misc income**	359	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,038,359	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,845,747	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	917,746	31
32	Health Care	2,755,641	32
33	General Administration	1,497,982	33
	B. Capital Expense		
34	Ownership	2,021,400	34
	C. Ancillary Expense		
35	Special Cost Centers	160,060	35
36	Provider Participation Fee	265,925	36
	D. Other Expenses (specify):		
37	**bad debt expense**	94,510	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,713,264	40
41	**Income before Income Taxes (line 30 minus line 40)****	132,483	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 132,483	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,439,934	44
45	Private Pay - Net Inpatient Revenue	486,870	45
46	Medicare - Net Inpatient Revenue	1,422,672	46
47	Other-(specify) **Commercial**	338,321	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,687,797	49

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

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

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

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	2,304	2,352	$ 83,394	$ 35.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,352	13,574	399,719	29.45	3
4	Licensed Practical Nurses	23,389	28,014	694,136	24.78	4
5	CNAs & Orderlies	56,275	62,432	669,655	10.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,982	6,538	77,977	11.93	10
11	Social Service Workers	1,728	1,829	36,258	19.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	14,319	16,582	174,741	10.54	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,653	1,843	36,269	19.68	17
18	Housekeepers	15,259	16,636	156,652	9.42	18
19	Laundry	3,537	4,282	38,497	8.99	19
20	Administrator	2,016	2,182	98,096	44.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,266	7,939	137,492	17.32	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	1,888	2,182	32,051	14.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,968	166,385	$ 2,634,937 *	$ 15.84	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	135	$ 6,741	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	183	9,162	10-3	38
39	Pharmacist Consultant	205	10,233	15-3	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	51	2,559	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	574	$ 28,695		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 Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laquanta Jordan	Administrator		$ 61,876
Nathan Wolf	Administrator		36,220
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 98,096

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
Polsinelli	Legal fees	$ 113
Bradley & Associates	Acct fees	5,946
Johnson, Goldburg	Acct fees	2,500
MTS Consulting	Prof fees	1,497
Infinity Healthcare	Mgmt fees	238,547
Gauthier & Kimmerling	Acct fees	4,700
Hinshaw & Culbertson	Legal fees	2,275
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 255,578

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 145,378
Unemployment Compensation Insurance	69,415
FICA Taxes	195,181
Employee Health Insurance	133,271
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
pension	31,256
employee expense	42,478
	4,759
TOTAL (agree to Schedule V, line 22, col.8)	$ 621,738

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	7,733
clia	150
sec of state	250
kankakee health dept	250
various	884
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,267

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
seminars	680
auto allowance	1,741
mileage	6,000
Seminar Expense	
continuing education	24
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,445

**See instructions.

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Nrsing & Reh # 0048033 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **yes**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **illinois council**

(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. $ **47,096** 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. $ **265,925**
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? **2%**
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 out of Schedule V? **n/a**

(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. **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.