FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 708-449-1900 **Fax #** 708-449-1500

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: **Telephone Number:** (317) 237- 5500
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 01/01/16 to 12/31/16 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) Flora Reznik
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

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: 01/01/16 Ending: 12/31/16

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	24,157	1,214	1,786	27,157	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,157	1,214	1,786	27,157	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.00%

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 07/01/06

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 1,404

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	166,653		39,552	206,205		206,205	(3,493)	202,712			1
2	Food Purchase		153,666		153,666		153,666	611	154,277			2
3	Housekeeping	139,450	42,737		182,187		182,187	386	182,573			3
4	Laundry	45,428	16,806		62,234		62,234		62,234			4
5	Heat and Other Utilities			145,907	145,907		145,907	521	146,428			5
6	Maintenance	54,475	45,396	67,917	167,788		167,788	936	168,724			6
7	Other (specify):*											7
8	TOTAL General Services	406,006	258,605	253,376	917,987		917,987	(1,039)	916,948			8
	B. Health Care and Programs											
9	Medical Director			18,001	18,001		18,001		18,001			9
10	Nursing and Medical Records	1,463,421	126,458	49,239	1,639,118		1,639,118	(34,282)	1,604,836			10
10a	Therapy			477,041	477,041		477,041		477,041			10a
11	Activities	90,333	14,855		105,188		105,188	2,454	107,642			11
12	Social Services	39,866		1,844	41,710		41,710		41,710			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*			8,010	8,010		8,010		8,010			15
16	TOTAL Health Care and Programs	1,593,620	141,313	554,135	2,289,068		2,289,068	(31,828)	2,257,240			16
	C. General Administration											
17	Administrative	80,692			80,692		80,692		80,692			17
18	Directors Fees											18
19	Professional Services			333,305	333,305		333,305	(138,812)	194,493			19
20	Dues, Fees, Subscriptions & Promotions			5,703	5,703		5,703	(23)	5,680			20
21	Clerical & General Office Expenses	154,106	39,008	69,874	262,988		262,988	114,942	377,930			21
22	Employee Benefits & Payroll Taxes			564,666	564,666		564,666	45,236	609,902			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,657	3,657		3,657	856	4,513			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			309,271	309,271		309,271	39,227	348,498			26
27	Other (specify):*											27
28	TOTAL General Administration	234,798	39,008	1,286,476	1,560,282		1,560,282	61,426	1,621,708			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,234,424	438,926	2,093,987	4,767,337		4,767,337	28,559	4,795,896			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: 01/01/16 Ending: 12/31/16

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			34,589	34,589		34,589	192,498	227,087			30
31	Amortization of Pre-Op. & Org.			2,525	2,525		2,525	238,735	241,260			31
32	Interest			148,970	148,970		148,970	230,899	379,869			32
33	Real Estate Taxes							102,892	102,892			33
34	Rent-Facility & Grounds			1,038,000	1,038,000		1,038,000	(1,032,672)	5,328			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,224,084	1,224,084		1,224,084	(267,648)	956,436			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		60,516	324	60,840		60,840		60,840			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			224,797	224,797		224,797		224,797			42
43	Other (specify):*			336,268	336,268		336,268	(336,268)				43
44	TOTAL Special Cost Centers		60,516	561,389	621,905		621,905	(336,268)	285,637			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,234,424	499,442	3,879,460	6,613,326		6,613,326	(575,357)	6,037,969			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: 01/01/16 Ending: 12/31/16

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	136,682	30		9
10	Interest and Other Investment Income	(1,622)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(38)	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	(4,007)	21		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	(336,268)	43		24
25	Fund Raising, Advertising and Promotional	(4,405)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,128)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (211,786)		$	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)	(363,571)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (363,571)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (575,357)		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

Momence Meadows Nrsing & Reh

ID# 0048033

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (1,834)	21	1
2	Lobbying Expenses	(294)	20	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**	(2,128)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(38)	(3,455)	0	0	0	0	0	0	0	0	0	(3,493)	1
2	Food Purchase	0	611	0	0	0	0	0	0	0	0	0	611	2
3	Housekeeping	0	386	0	0	0	0	0	0	0	0	0	386	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	521	0	0	0	0	0	0	0	0	0	521	5
6	Maintenance	0	936	0	0	0	0	0	0	0	0	0	936	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(38)	(1,001)	0	0	0	0	0	0	0	0	0	(1,039)	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	(34,282)	0	0	0	0	0	0	0	0	0	(34,282)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,454	0	0	0	0	0	0	0	0	0	2,454	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	(31,828)	0	0	0	0	0	0	0	0	0	(31,828)	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	(150,181)	11,369	0	0	0	0	0	0	0	0	(138,812)	19
20	Fees, Subscriptions & Promotions	(294)	271	0	0	0	0	0	0	0	0	0	(23)	20
21	Clerical & General Office Expenses	(10,246)	125,188	0	0	0	0	0	0	0	0	0	114,942	21
22	Employee Benefits & Payroll Taxes	0	45,236	0	0	0	0	0	0	0	0	0	45,236	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	856	0	0	0	0	0	0	0	0	0	856	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	319	38,908	0	0	0	0	0	0	0	0	39,227	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(10,540)	21,689	50,277	0	0	0	0	0	0	0	0	61,426	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,578)	(11,140)	50,277	0	0	0	0	0	0	0	0	28,559	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	136,682	0	55,816	0	0	0	0	0	0	0	0	192,498	30
31	Amortization of Pre-Op. & Org.	0	0	238,735	0	0	0	0	0	0	0	0	238,735	31
32	Interest	(1,622)	0	232,521	0	0	0	0	0	0	0	0	230,899	32
33	Real Estate Taxes	0	0	102,892	0	0	0	0	0	0	0	0	102,892	33
34	Rent-Facility & Grounds	0	0	(1,032,672)	0	0	0	0	0	0	0	0	(1,032,672)	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**	135,060	0	(402,708)	0	0	0	0	0	0	0	0	(267,648)	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):*	(336,268)	0	0	0	0	0	0	0	0	0	0	(336,268)	43
44	**TOTAL Special Cost Centers**	(336,268)	0	0	0	0	0	0	0	0	0	0	(336,268)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(211,786)	(11,140)	(352,431)	0	0	0	0	0	0	0	0	(575,357)	45

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Blisko	31.50	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
Moishe Gubin	33.60	Belhaven Nursing & Rehab Center	Chicago	Momence Meadows Realty, LLC		Realty Co.
A & F Realty	31.50	City View Multicare Center	Cicero			
Bernard Steinberg	3.40	Continental Nursing & Rehab Center	Chicago			
		Forest View Nursing & Rehab Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Nursing & Rehab Center	Bridgeview			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 14,079	Infinity Healthcare Management		$ 10,624	$ (3,455)	1
2	V	2	Food Purchase		Infinity Healthcare Management		611	611	2
3	V	3	Housekeeping		Infinity Healthcare Management		386	386	3
4	V	5	Utilities		Infinity Healthcare Management		521	521	4
5	V	6	Maintenance		Infinity Healthcare Management		936	936	5
6	V	10	Nursing	48,989	Infinity Healthcare Management		14,707	(34,282)	6
7	V	11	Activities		Infinity Healthcare Management		2,454	2,454	7
8	V	19	Professional Fees	264,747	Infinity Healthcare Management		114,566	(150,181)	8
9	V	20	Dues, Fees, Subs & Promotions		Infinity Healthcare Management		271	271	9
10	V	21	Clerical & Office Expenses	76,260	Infinity Healthcare Management		201,448	125,188	10
11	V	22	Employee Benefits		Infinity Healthcare Management		45,236	45,236	11
12	V	24	Travel & Seminar	504	Infinity Healthcare Management		1,360	856	12
13	V	26	Insurance		Infinity Healthcare Management		319	319	13
14	Total			$ 404,579			$ 393,439	$ * (11,140)	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: 01/01/16 Ending: 12/31/16

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	30	Depreciation	$	Infinity Healthcare Management		$ 226	$ 226	15
16	V	32	Interest		Infinity Healthcare Management		2,931	2,931	16
17	V	34	Rent		Infinity Healthcare Management		5,328	5,328	17
18	V								18
19	V								19
20	V	19	Professional Fees		Momence Meadows Realty, LLC		11,369	11,369	20
21	V	21	Office Expense		Momence Meadows Realty, LLC				21
22	V	26	Insurance		Momence Meadows Realty, LLC		38,908	38,908	22
23	V	30	Depreciation		Momence Meadows Realty, LLC		55,590	55,590	23
24	V	31	Amortization		Momence Meadows Realty, LLC		238,735	238,735	24
25	V	32	Interest		Momence Meadows Realty, LLC		229,590	229,590	25
26	V	33	Property Taxes		Momence Meadows Realty, LLC		102,892	102,892	26
27	V	34	Rent	1,038,000	Momence Meadows Realty, LLC			(1,038,000)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,038,000			$ 685,569	$ * (352,431)	39

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Niles Nursing & Rehab Center	Niles				1
2			Oak Lawn Respiratory & Rehab Center	Oak Lawn				2
3			Parker Nursing & Rehab Center	Streator				3
4			Parkshore Estates Nursing & Rehab Ctr	Chicago				4
5			Southpoint Nursing & Rehab Center	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomingdale				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: 01/01/16 Ending: 12/31/16

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 Nrsing & Reh # 0048033 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	$ 5,789,970	10/1/36	3.9400	$ 229,590	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		x	working capital	None	8/31/14	26,000,000	4,820,640	8/31/18	various	134,971	6
7	Infinity Funding	x		working capital	None	various	2,735,000	500,000	various	various	16,930	7
8												8
9	TOTAL Facility Related				$35,001.00		$ 35,095,700	$ 11,110,610			$ 381,491	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	$ 11,110,610			$ 381,491	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 32,497 Line # 26

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

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 41,016	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.)		$ 73,616	2
3. Under or (over) accrual (line 2 minus line 1).		$ 32,600	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 70,292	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.		$ 102,892	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	45,089	8
	2012	74,060	9
	2013	83,362	10
	2014	85,332	11
	2015	73,616	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Momence Meadows Nrsing & Reh COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0048033

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-11-19-306-007	Nursing Home	$ 73,615.78	$ 73,615.78
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,615.78	$ 73,615.78

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/16 Ending: 12/31/16

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 07/01/06

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	FACILITY		7/1/2006	$ 180,000	1
2					2
3	TOTALS			$ 180,000	3

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 2,839,000	$ 55,590	39	$ 72,795	$ 17,205	$ 619,888	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse Call Light			11/30/2006	26,050	668	39	668		7,348	9
10	A/C on Roof			1/20/2007	420	11	39	11		103	10
11	A/C on Roof			2/16/2007	4,424	113	39	113		1,076	11
12	Nurse Call System			5/30/2007	280	7	39	7		68	12
13	Replace Locks			11/15/2007	7,700	197	39	197		1,874	13
14	Replace Locks			11/15/2007	104	3	39	3		26	14
15	Exhaust Vent and Filter			11/27/2007	932	24	39	24		227	15
16	Shower Remodeling			6/20/2008	3,750	96		96		865	16
17	New Compressor on Walk In Freezer			1/24/2008	2,158	55	39	55		497	17
18	Sidewalks			3/10/2008	4,289	110	39	110		990	18
19	Asphalt Driveway			4/9/2008	5,775	148	39	148		1,332	19
20	Asphalt Driveway			4/22/2008	5,775	148	39	148		1,332	20
21	Shower Room Tiles			4/30/2008	9,483	243	39	243		2,188	21
22	Drywall, Ultrasteel, Concrete, Sand, etc			5/31/2008	1,129	29	39	29		261	22
23	Mortar			6/8/2008	321	8	39	8		74	23
24	Grout and Mortar			6/20/2008	83	2	39	2		19	24
25	Drywall, Mortar and Paint			7/1/2008	523	13	39	13		120	25
26	Adhesive, Mortar, etc			7/5/2008	597	15	39	15		137	26
27	Adhesive, Mortar, etc			7/15/2008	126	3	39	3		29	27
28	Misc Supplies for Shower Remodeling			7/31/2008	61	2	39	2		15	28
29	Replace Heat Exchanger in Kitchen Roof-Top			12/11/2008	2,936	75	39	75		677	29
30	Carpet			12/29/2009	4,480	115	39	115		919	30
31	Remodeling (Nurse Station, Ceiling, Lighting, Wallpaper)			2/16/2009	108,504	2,782	39	2,782		22,260	31
32	Roof Improvements			4/5/2009	3,500	90	39	90		719	32
33	Roof Improvements			12/21/2009	3,500	90	39	90		719	33
34	Building & Shower Remodeling w/ Towel Rack			11/2/2010	1,714	44	39	44		308	34
35	Shower Remodeling & Wall Base Lining			11/17/2010	1,500	38	39	38		268	35
36	Fire Sprinkler			12/24/2010	1,395	36	39	36		251	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: 01/01/16 Ending: 12/31/16

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	$	$ 1,418	37
38	Maintenance, Repairs, Replacements & Wages	11/23/2010	4,485	115	39	115		805	38
39	Materials	12/9/2010	1,482	38	39	38		266	39
40	Materials for Hot Water Valve & Labor	3/30/2010	1,814	47	39	47		326	40
41	Supplies	11/18/2010	1,536	39	39	39		275	41
42	Replace Flame Sensor/Ignitor & Labor	12/1/2010	856	22		22		154	42
43	Partial Billing for Cooler Replacement	12/8/2010	2,445	63	39	63		439	43
44	Repatched Walls, Resealed Gravel, Reflashed Drain	3/19/2010	1,650	42	39	42		295	44
45	New Soffit and Installed SPMB Patch	4/12/2010	950	24	39	24		170	45
46	Installed New Shingle Roof & Repaired Rotted Wood	11/22/2010	3,950	101	39	101		708	46
47	Remove Snow, Applied Patch to Roof, Patched 2 Holes	12/27/2010	750	19	39	19		134	47
48	Cabling for New TV Jacks ($55/jack)	5/24/2010	8,000	205	39	205		1,435	48
49	Repaired Ramp and Asphalt	11/18/2010	2,395	61	39	61		429	49
50	Repair Leaks on Main Water Supply and Dishwasher	6/8/2011	1,297	33	39	33		199	50
51	Replacement of Heat Exchanger	12/2/2010	1,384	35	39	35		212	51
52	Cooler Replacement	12/14/2010	2,445	63	39	63		377	52
53	Heavy Asphalt Coating to Roof	5/23/2011	950	24	39	24		145	53
54	Patching of roof and Replacement of Shingles	10/24/2011	3,000	77	39	77		462	54
55	Retrofit of light fixtures	4/28/2011	16,446	422	39	422		2,531	55
56	Stone/Steel Work and Concrete Replacement	9/1/2011	750	19	39	19		115	56
57	Stone/Steel Work and Concrete Replacement	9/6/2011	750	19	39	19		115	57
58	Replace heat exchanger	11/2/2012	3,775	97	39	97		484	58
59	Replace compressor in freezer	7/6/2012	3,385	87	39	87		434	59
60		7/2/2012	61,769	1,584	39	1,584		7,918	60
61									61
62	2007 Assets not allowed for increased capital reimbursement	2007	3,936	101	39	101		958	62
63	2008 Assets not allowed for increased capital reimbursement	2008	3,751	96	39	96		865	63
64	2010 Assets not allowed for increased capital reimbursement	2010	7,000	179	39	179		1,255	64
65	2011 Assets not allowed for increased capital reimbursement	2011	5,078	130	39	130		781	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,194,436	$ 64,700		$ 81,905	$ 17,205	$ 688,295	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,194,436	$ 64,700		$ 81,905	$ 17,205	$ 688,295	1
2	Vinyl tile	8/27/2013	1,373	35	39	35		123	2
3	Heat Exchanger	5/14/2013	2,670	68	39	68		239	3
4	Sprinkler piping & relocating	3/13/2013	48,000	1,231	39	1,231		4,308	4
5	Survey work for sprinkler piping	2/26/2013	3,600	92	39	92		322	5
6	Vinyl tiles - dining room	9/2/2013	1,375	35	39	35		123	6
7	Electrical wiring - dishwasher	12/5/2013	2,575	66	39	66		231	7
8									8
9	3 water heaters removed & new installed	4/4/2014	23,995	615	39	615		1,846	9
10	Patch wall flashings	5/27/2014	4,850	124	39	124		372	10
11	Nurses station walls / cabinets	5/28/2014	24,900	638	39	638		1,915	11
12	Patch cords & cables	3/6/2014	2,583	66	39	66		198	12
13	GAF roofing system	6/19/2014	63,400	1,626	39	1,626		4,880	13
14	Replace compressor in "C" wing	7/25/2014	3,373	86	39	86		258	14
15	Rental generator	3/27/2014	9,182	235	39	235		705	15
16	New door for walk-in freezer	8/22/2014	3,046	78	39	78		234	16
17	Kitchen flooring / repair leak	8/29/2014	2,253	58	39	58		174	17
18	Install booster pump	8/29/2014	1,700	44	39	44		132	18
19	Electric repairs in kitchen	8/29/2014	5,975	153	39	153		459	19
20	Kitchen flooring / repair leak	9/2/2014	7,550	194	39	194		582	20
21	Remodel & install tile in 2 rooms & bathroom	10/13/2014	1,620	42	39	42		126	21
22	Remodel & install tile in 2 rooms & bathroom	11/9/2014	2,405	62	39	62		186	22
23									23
24	Heat Exchanger	2/12/2016	3,300	85	39	85		85	24
25	Hot Water Heater for C Wing & Kitchen	8/12/2016	3,045	78	39	78		78	25
26	New Pump & Pipe for Cafeteria	8/3/2016	2,795	72	39	72		72	26
27	Installation of Hot Water Heater	9/15/2016	2,525	65	39	65		65	27
28	Repair Hot Water Heater in D Wing	9/23/2016	2,583	65	39	65		65	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,425,110	$ 70,613		$ 87,818	$ 17,205	$ 706,073	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: 01/01/16 Ending: 12/31/16

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	$ 666,932	$ 16,959	$ 133,386	$ 116,427	5-7	$ 607,076	71
72	Current Year Purchases	29,416	2,833	5,883	3,050	5-7	2,833	72
73	Fully Depreciated Assets					5-7		73
74								74
75	TOTALS	$ 696,348	$ 19,792	$ 139,269	$ 119,477		$ 609,909	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,301,458	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 90,405	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 227,087	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 136,682	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,315,982	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: 01/01/16 Ending: 12/31/16

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 01/01/16 Ending: 12/31/16

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.

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	$	2,844	$ 186,380	$	2,844	$ 186,380	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		54	6,613		54	6,613	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,647	182,798		3,647	182,798	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				54,730		54,730	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): XRAY	39-2					1,293		1,293	12
13	Other (specify): LAB	39-2					4,494		4,494	13
14	TOTAL			$	6,545	$ 375,791	$ 60,517	6,545	$ 436,308	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:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ (133,260)	$ 101,590	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,919,550	1,919,549	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	180,423	180,423	6
7	Other Prepaid Expenses	3,980	3,980	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		65,790	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,970,693	$ 2,271,332	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		180,000	13
14	Buildings, at Historical Cost		2,839,000	14
15	Leasehold Improvements, at Historical Cost	586,111	586,111	15
16	Equipment, at Historical Cost	269,347	696,347	16
17	Accumulated Depreciation (book methods)	(269,098)	(1,315,986)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	135,438	3,716,453	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(28,653)	(3,072,937)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Replacement Reserve**		183,411	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 693,145	$ 3,812,399	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,663,838	$ 6,083,731	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 713,350	$ 780,161	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,988	36,988	28
29	Short-Term Notes Payable		199,715	29
30	Accrued Salaries Payable	71,469	71,469	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,697	9,697	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		18,287	33
34	Deferred Compensation	75	75	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	4,820,640	4,820,640	36
37	Working Capital	(500,000)	(500,000)	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,152,219	$ 5,437,032	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	500,000	500,000	39
40	Mortgage Payable		5,590,255	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)**	$ 500,000	$ 6,090,255	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,652,219	$ 11,527,287	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,988,381)	$ (5,443,556)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,663,838	$ 6,083,731	48

***(See instructions.)**

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,096,474)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,096,474)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(891,907)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (891,907)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,988,381)	24 *

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

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 5,238,585	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,238,585	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	431,645	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 431,645	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	46,733	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	931	19
20	Radiology and X-Ray	288	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 47,952	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,402	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,402	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Revenue	1,834	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,834	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,721,418	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	917,987	31
32	Health Care	2,289,067	32
33	General Administration	1,560,282	33
	B. Capital Expense		
34	Ownership	1,224,084	34
	C. Ancillary Expense		
35	Special Cost Centers	60,840	35
36	Provider Participation Fee	224,797	36
	D. Other Expenses (specify):		
37	Bad Debt Expense	336,268	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,613,325	40
41	**Income before Income Taxes (line 30 minus line 40)****	(891,907)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (891,907)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,175,064	44
45	Private Pay - Net Inpatient Revenue	246,335	45
46	Medicare - Net Inpatient Revenue	436,730	46
47	Other-(specify)	380,456	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,238,585	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: 01/01/16 Ending: 12/31/16

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	4,261	4,290	$ 85,465	$ 19.92	1
2	Assistant Director of Nursing	2,639	3,067	100,191	32.67	2
3	Registered Nurses	6,954	8,377	255,582	30.51	3
4	Licensed Practical Nurses	13,471	15,320	413,040	26.96	4
5	CNAs & Orderlies	43,276	47,918	566,777	11.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,201	7,923	90,333	11.40	9
10	Activity Assistants					10
11	Social Service Workers	2,069	2,124	39,866	18.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,302	13,793	166,653	12.08	15
16	Dishwashers					16
17	Maintenance Workers	3,868	4,174	54,475	13.05	17
18	Housekeepers	11,441	12,513	139,450	11.14	18
19	Laundry	3,771	4,116	45,428	11.04	19
20	Administrator	1,675	1,885	80,692	42.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,728	13,040	166,143	12.74	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	1,862	2,056	30,329	14.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,518	140,596	$ 2,234,424 *	$ 15.89	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	402	$ 14,079	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,407	49,239	10-3	38
39	Pharmacist Consultant	160	8,010	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2,025	101,250	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	30	1,044	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,024	$ 173,622		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: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tara Holmes	Administrator		$ 12,465
Jordan LaQuanta	Administrator		68,227
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,692

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	Accounting	$ 15,844
Johnson & Goldburg	Accounting	2,900
Capital One	Audit Fees	3,673
US Legal Support Inc	Legal	85
Segal McCambridge Singer & Mahon	Legal	16,887
Infinity Funding, LLC	Professional	16,057
MTS Consulting, Inc	Professional	6,238
Pinnacle Quality Insight	Professional	779
Infinity Healthcare Management	Professional/Mgmt	270,093
Nashib Hashmi, MD	Professional	750
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 333,305

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,105
Unemployment Compensation Insurance	102,449
FICA Taxes	183,159
Employee Health Insurance	201,265
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	34,156
Employee Expenses	17,493
Uniform Expense	4,400
Work Comp Settlement	3,076
Employee Background Checks	799
TOTAL (agree to Schedule V, line 22, col.8)	$ 609,902

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

Description	Line #	Amount
		$
TOTAL		$

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	
IL Dept of Public Health	35
Kankakee County Health Department	350
CLIA Lab	150
IHCA / IHCA PAC	4,874
HO Licenses & Permits	271
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,680

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
mileage	5,175
continuing education	(663)
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,513

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Momence Meadows Nrsing & Reh # 0048033 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 of Long Term Care (4,874)**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **46,037** 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 fo
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 Departmen
during this cost report period. $ **224,797**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees