		FOR BHF USE				

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 Nursing & Rehabilitation Center, LLC

Address: 500 South Walnut Street (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	PROPRIETARY	GOVERNMENTAL
[ ] 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 1/1/18 to 12/31/18 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)	Paresh Vipani
	(Title)	CFO
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 Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	140	Skilled (SNF)	140	51,100	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	22,373		3,413	25,786	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,373		3,413	25,786	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.46%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 07/01/06 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 881

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

STATE OF ILLINOIS

Facility Name & ID Number **Momence Meadows Nursing & Rehabilitatior** **#** **0048033** **Report Period Beginning:** **1/1/18** **Ending:** **12/31/18**

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	180,295	19,199	4,512	204,006		204,006	(15)	203,991			1
2	Food Purchase		155,046		155,046		155,046	720	155,766			2
3	Housekeeping	122,860	12,762		135,622		135,622	8	135,630			3
4	Laundry	68,262	8,490		76,752		76,752		76,752			4
5	Heat and Other Utilities			150,104	150,104		150,104	1,190	151,294			5
6	Maintenance	73,222	40,004	74,485	187,711		187,711	652	188,363			6
7	Other (specify):*											7
8	**TOTAL General Services**	444,639	235,501	229,101	909,241		909,241	2,555	911,796			8
	B. Health Care and Programs											
9	Medical Director			23,000	23,000		23,000		23,000			9
10	Nursing and Medical Records	1,528,529	100,525	51,457	1,680,511		1,680,511	(30,652)	1,649,859			10
10a	Therapy			211,764	211,764		211,764		211,764			10a
11	Activities	93,819	8,458		102,277		102,277		102,277			11
12	Social Services	61,418		9,954	71,372		71,372		71,372			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			7,578	7,578		7,578	(162)	7,416			15
16	**TOTAL Health Care and Programs**	1,683,766	108,983	303,753	2,096,502		2,096,502	(30,814)	2,065,688			16
	C. General Administration											
17	Administrative	99,120			99,120		99,120	(12,457)	86,663			17
18	Directors Fees											18
19	Professional Services			368,973	368,973		368,973	(212,707)	156,266			19
20	Dues, Fees, Subscriptions & Promotions			4,915	4,915		4,915	(102)	4,813			20
21	Clerical & General Office Expenses	88,953	37,754	253,478	380,185		380,185	(11,210)	368,975			21
22	Employee Benefits & Payroll Taxes			505,317	505,317		505,317	16,541	521,858			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,896	12,896		12,896	(3,020)	9,876			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			291,234	291,234		291,234	37,475	328,709			26
27	Other (specify):*											27
28	**TOTAL General Administration**	188,073	37,754	1,436,813	1,662,640		1,662,640	(185,480)	1,477,160			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,316,478	382,238	1,969,667	4,668,383		4,668,383	(213,739)	4,454,644			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 Nursing & Rehabilitation Center, LLC #0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			36,630	36,630		36,630	193,851	230,481			30
31	Amortization of Pre-Op. & Org.			2,820	2,820		2,820	238,735	241,555			31
32	Interest			694,937	694,937		694,937	202,596	897,533			32
33	Real Estate Taxes							68,316	68,316			33
34	Rent-Facility & Grounds			1,038,000	1,038,000		1,038,000	(1,035,645)	2,355			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,772,387	1,772,387		1,772,387	(332,147)	1,440,240			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2	2		2		2			38
39	Ancillary Service Centers		59,441		59,441		59,441	(1,268)	58,173			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			226,477	226,477		226,477		226,477			42
43	Other (specify):*			60,827	60,827		60,827	(60,827)				43
44	TOTAL Special Cost Centers		59,441	287,306	346,747		346,747	(62,095)	284,652			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,316,478	441,679	4,029,360	6,787,517		6,787,517	(607,981)	6,179,536			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 Nursing & Rehabilitation Center, LL # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Reference	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	121,056	30		9
10	Interest and Other Investment Income	(7,098)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(11,425)	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	(60,827)	43		24
25	Fund Raising, Advertising and Promotional	(8,314)	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	(3,602)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 29,775		$	30

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)	(637,756)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (637,756)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (607,981)		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

BHF USE ONLY

48		49		50		51		52	

STATE OF ILLINOIS

Momence Meadows Nursing & Rehabilitation Center, LLC

ID# 0048033

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income	$ (1,094)	10	1
2	Misc Income	(919)	21	2
3	PAC Expense	(84)	20	3
4	RP Profit	(75)	10	4
5	RP Profit	(162)	15	5
6	RP Profit	(1,268)	39	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**	(3,602)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Momence Meadows Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	(15)	0	0	0	0	0	0	0	0	0	0	(15)	1
2	Food Purchase	0	720	0	0	0	0	0	0	0	0	0	720	2
3	Housekeeping	0	8	0	0	0	0	0	0	0	0	0	8	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,190	0	0	0	0	0	0	0	0	0	1,190	5
6	Maintenance	0	652	0	0	0	0	0	0	0	0	0	652	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(15)	2,570	0	0	0	0	0	0	0	0	0	2,555	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	(1,169)	(29,483)	0	0	0	0	0	0	0	0	0	(30,652)	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):*	(162)	0	0	0	0	0	0	0	0	0	0	(162)	15
16	**TOTAL Health Care and Programs**	(1,331)	(29,483)	0	0	0	0	0	0	0	0	0	(30,814)	16
	C. General Administration													
17	Administrative	0	(12,457)	0	0	0	0	0	0	0	0	0	(12,457)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(220,052)	7,345	0	0	0	0	0	0	0	0	(212,707)	19
20	Fees, Subscriptions & Promotions	(84)	(18)	0	0	0	0	0	0	0	0	0	(102)	20
21	Clerical & General Office Expenses	(20,658)	9,448	0	0	0	0	0	0	0	0	0	(11,210)	21
22	Employee Benefits & Payroll Taxes	0	16,541	0	0	0	0	0	0	0	0	0	16,541	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(3,020)	0	0	0	0	0	0	0	0	0	(3,020)	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	635	36,840	0	0	0	0	0	0	0	0	37,475	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(20,742)	(208,923)	44,185	0	0	0	0	0	0	0	0	(185,480)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,088)	(235,836)	44,185	0	0	0	0	0	0	0	0	(213,739)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Momence Meadows Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	121,056	0	72,795	0	0	0	0	0	0	0	0	193,851	30
31	Amortization of Pre-Op. & Org.	0	0	238,735	0	0	0	0	0	0	0	0	238,735	31
32	Interest	(7,098)	0	209,694	0	0	0	0	0	0	0	0	202,596	32
33	Real Estate Taxes	0	0	68,316	0	0	0	0	0	0	0	0	68,316	33
34	Rent-Facility & Grounds	0	0	(1,035,645)	0	0	0	0	0	0	0	0	(1,035,645)	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**	113,958	0	(446,105)	0	0	0	0	0	0	0	0	(332,147)	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	(1,268)	0	0	0	0	0	0	0	0	0	0	(1,268)	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):*	(60,827)	0	0	0	0	0	0	0	0	0	0	(60,827)	43
44	**TOTAL Special Cost Centers**	(62,095)	0	0	0	0	0	0	0	0	0	0	(62,095)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	29,775	(235,836)	(401,920)	0	0	0	0	0	0	0	0	(607,981)	45

Facility Name & ID Number Momence Meadows Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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%	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Mgmt Co
Moishe Gubin	33.6%	Belhaven Nursing & Rehab Center	Chicago	Momence Meadows Realty, LLC		Realty Co
A & F Realty	31.5%	City View Multicare Center	Cicero			
Bernard Steinberg	3.4%	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	$	Infinity Healthcare Management		$	$	1
2	V	2	Food Purchases		Infinity Healthcare Management		720	720	2
3	V	3	Housekeeping		Infinity Healthcare Management		8	8	3
4	V	5	Utilities		Infinity Healthcare Management		1,190	1,190	4
5	V	6	Maintenance		Infinity Healthcare Management		652	652	5
6	V	10	Nursing	51,583	Infinity Healthcare Management		22,100	(29,483)	6
7	V	17	Administrative	12,457	Infinity Healthcare Management			(12,457)	7
8	V	19	Professional Fees	221,060	Infinity Healthcare Management		1,008	(220,052)	8
9	V	20	Dues, Fees, Subs & Promotions	88	Infinity Healthcare Management		70	(18)	9
10	V	21	Clerical & Office Expenses	113,851	Infinity Healthcare Management		123,299	9,448	10
11	V	22	Employee Benefits	2,228	Infinity Healthcare Management		18,769	16,541	11
12	V	24	Travel & Seminar	5,252	Infinity Healthcare Management		2,232	(3,020)	12
13	V	26	Insurance		Infinity Healthcare Management		635	635	13
14	Total			$ 406,519			$ 170,683	$ * (235,836)	14

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

Facility Name & ID Number Momence Meadows Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Infinity Healthcare Management		$	$	15
16	V	32	Interest		Infinity Healthcare Management		2,057	2,057	16
17	V	34	Rent		Infinity Healthcare Management		2,355	2,355	17
18	V								18
19	V	19	Professional Fees		Momence Meadows Realty, LLC		7,345	7,345	19
20	V	26	Insurance		Momence Meadows Realty, LLC		36,840	36,840	20
21	V	30	Depreciation		Momence Meadows Realty, LLC		72,795	72,795	21
22	V	31	Amortization		Momence Meadows Realty, LLC		238,735	238,735	22
23	V	32	Interest		Momence Meadows Realty, LLC		207,637	207,637	23
24	V	33	Property Taxes		Momence Meadows Realty, LLC		68,316	68,316	24
25	V	34	Rent	1,038,000	Momence Meadows Realty, LLC			(1,038,000)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,038,000			$ 636,080	$ * (401,920)	39

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

Facility Name & ID Number Momence Meadows Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			Landmark of Des Plaines Rehab Center	Des Plaines				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 Nursing & Rehabilitatio # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	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 Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Nursing & Rehabilitatior # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage	$35,002.00	8/21/13	$ 6,360,700	$ 5,382,839	10/1/36	3.9400	$ 207,637	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		X	Working Capital	None	8/31/14	26,000,000	6,858,631	8/31/19	various	131,970	6
7	Infinity Funding	X		Working Capital	Various	Various	Various		various	various	565,024	7
8												8
9	TOTAL Facility Related				$35,002.00		$ 32,360,700	$ 12,241,470			$ 904,631	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 32,360,700	$ 12,241,470			$ 904,631	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 30,502 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 Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Line	Description		Amount	
1	1. Real Estate Tax accrual used on 2017 report.	$	81,595	1
2	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.)	$	75,741	2
3	3. Under or (over) accrual (line 2 minus line 1).	$	(5,854)	3
4	4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	74,170	4
5	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	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	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	68,316	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2013	83,362	8
2014	85,332	9
2015	73,616	10
2016	75,527	11
2017	75,741	12

FOR BHF USE ONLY

Line	Description			Line
13	FROM R. E. TAX STATEMENT FOR 2017	$		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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Momence Meadows Nursing & Rehabilitation Center, LLC 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 2017 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 2017.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	05-11-19-306-007	Nursing Facility	$ 75,740.86	$ 75,740.86
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,740.86	$ 75,740.86

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.

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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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:
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 Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 72,795	39	$ 72,795	$	$ 782,683	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse Call Light			11/30/2006	26,050	668	39	668		8,684	9
10	A/C on Roof			1/20/2007	420	11	39	11		125	10
11	A/C on Roof			2/16/2007	4,424	113	39	113		1,302	11
12	Nurse Call System			5/30/2007	280	7	39	7		82	12
13	Replace Locks			11/15/2007	7,700	197	39	197		2,268	13
14	Replace Locks			11/15/2007	104	3	39	3		32	14
15	Exhaust Vent and Filter			11/27/2007	932	24	39	24		275	15
16	Shower Remodeling			6/20/2008	3,750	96	39	96		1,057	16
17	New Compressor on Walk In Freezer			1/24/2008	2,158	55	39	55		607	17
18	Sidewalks			3/10/2008	4,289	110	39	110		1,210	18
19	Asphalt Driveway			4/9/2008	5,775	148	39	148		1,628	19
20	Asphalt Driveway			4/22/2008	5,775	148	39	148		1,628	20
21	Shower Room Tiles			4/30/2008	9,483	243	39	243		2,674	21
22	Drywall, Ultrasteel, Concrete, Sand, etc			5/31/2008	1,129	29	39	29		319	22
23	Mortar			6/8/2008	321	8	39	8		90	23
24	Grout and Mortar			6/20/2008	83	2	39	2		23	24
25	Drywall, Mortar and Paint			7/1/2008	523	13	39	13		146	25
26	Adhesive, Mortar, etc			7/5/2008	597	15	39	15		167	26
27	Adhesive, Mortar, etc			7/15/2008	126	3	39	3		35	27
28	Misc Supplies for Shower Remodeling			7/31/2008	61	2	39	2		19	28
29	Replace Heat Exchanger in Kitchen Roof-Top			12/11/2008	2,936	75	39	75		827	29
30	Carpet			12/29/2009	4,480	115	39	115		1,149	30
31	Remodeling (Nurse Station, Ceiling, Lighting, Wallpaper)			2/16/2009	108,504	2,782	39	2,782		27,824	31
32	Roof Improvements			4/5/2009	3,500	90	39	90		899	32
33	Roof Improvements			12/21/2009	3,500	90	39	90		899	33
34	Building & Shower Remodeling w/ Towel Rack			11/2/2010	1,714	44	39	44		396	34
35	Shower Remodeling & Wall Base Lining			11/17/2010	1,500	38	39	38		344	35
36	Fire Sprinkler			12/24/2010	1,395	36	39	36		323	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 Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 1,824	37
38	Maintenance, Repairs, Replacements & Wages	11/23/2010	4,485	115	39	115		1,035	38
39	Materials	12/9/2010	1,482	38	39	38		342	39
40	Materials for Hot Water Valve & Labor	3/30/2010	1,814	47	39	47		420	40
41	Supplies	11/18/2010	1,536	39	39	39		353	41
42	Replace Flame Sensor/Ignitor & Labor	12/1/2010	856	22	39	22		198	42
43	Partial Billing for Cooler Replacement	12/8/2010	2,445	63	39	63		565	43
44	Repatched Walls, Resealed Gravel, Reflashed Drain	3/19/2010	1,650	42	39	42		379	44
45	New Soffit and Installed SPMB Patch	4/12/2010	950	24	39	24		218	45
46	Installed New Shingle Roof & Repaired Rotted Wood	11/22/2010	3,950	101	39	101		910	46
47	Remove Snow, Applied Patch to Roof, Patched 2 Holes	12/27/2010	750	19	39	19		172	47
48	Cabling for New TV Jacks ($55/jack)	5/24/2010	8,000	205	39	205		1,845	48
49	Repaired Ramp and Asphalt	11/18/2010	2,395	61	39	61		551	49
50	Repair Leaks on Main Water Supply and Dishwasher	6/8/2011	1,297	33	39	33		265	50
51	Replacement of Heat Exchanger	12/2/2010	1,384	35	39	35		282	51
52	Cooler Replacement	12/14/2010	2,445	63	39	63		503	52
53	Heavy Asphalt Coating to Roof	5/23/2011	950	24	39	24		193	53
54	Patching of roof and Replacement of Shingles	10/24/2011	3,000	77	39	77		616	54
55	Retrofit of light fixtures	4/28/2011	16,446	422	39	422		3,375	55
56	Stone/Steel Work and Concrete Replacement	9/1/2011	750	19	39	19		153	56
57	Stone/Steel Work and Concrete Replacement	9/6/2011	750	19	39	19		153	57
58	Replace heat exchanger	11/2/2012	3,775	97	39	97		678	58
59	Replace compressor in freezer	7/6/2012	3,385	87	39	87		608	59
60		7/2/2012	61,769	1,584	39	1,584		11,086	60
61									61
62	2007 Assets not allowed for increased capital reimbursement	2007	3,936	101	39	101		1,160	62
63	2008 Assets not allowed for increased capital reimbursement	2008	3,751	96	39	96		1,057	63
64	2010 Assets not allowed for increased capital reimbursement	2010	7,000	179	39	179		1,613	64
65	2011 Assets not allowed for increased capital reimbursement	2011	5,078	130	39	130		1,041	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,194,438	$ 81,905		$ 81,905	$	$ 869,310	70

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

Facility Name & ID Number Momence Meadows Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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		$ 3,194,438	$ 81,905		$ 81,905	$	$ 869,310	1
2	Vinyl tile	8/27/2013	1,373	35	39	35		193	2
3	Heat Exchanger	5/14/2013	2,670	68	39	68		375	3
4	Sprinkler piping & relocating	3/13/2013	48,000	1,231	39	1,231		6,770	4
5	Survey work for sprinkler piping	2/26/2013	3,600	92	39	92		506	5
6	Vinyl tiles - dining room	9/2/2013	1,375	35	39	35		193	6
7	Electrical wiring - dishwasher	12/5/2013	2,575	66	39	66		363	7
8									8
9	3 water heaters removed & new installed	4/4/2014	23,995	616	39	615	(1)	3,079	9
10	Patch wall flashings	5/27/2014	4,850	124	39	124		620	10
11	Nurses station walls / cabinets	5/28/2014	24,900	639	39	638	(1)	3,194	11
12	Patch cords & cables	3/6/2014	2,583	66	39	66		330	12
13	GAF roofing system	6/19/2014	63,400	1,628	39	1,626	(2)	8,138	13
14	Replace compressor in "C" wing	7/25/2014	3,373	86	39	86		430	14
15	Rental generator	3/27/2014	9,182	235	39	235		1,175	15
16	New door for walk-in freezer	8/22/2014	3,046	78	39	78		390	16
17	Kitchen flooring / repair leak	8/29/2014	2,253	58	39	58		290	17
18	Install booster pump	8/29/2014	1,700	44	39	44		220	18
19	Electric repairs in kitchen	8/29/2014	5,975	153	39	153		765	19
20	Kitchen flooring / repair leak	9/2/2014	7,550	194	39	194		970	20
21	Remodel & install tile in 2 rooms & bathroom	10/13/2014	1,620	42	39	42		210	21
22	Remodel & install tile in 2 rooms & bathroom	11/9/2014	2,405	62	39	62		310	22
23									23
24	Heat Exchanger	2/12/2016	3,300	85	39	85		255	24
25	Hot Water Heater for C Wing & Kitchen	8/12/2016	3,045	78	39	78		234	25
26	New Pump & Pipe for Cafeteria	8/3/2016	2,795	72	39	72		216	26
27	Installation of Hot Water Heater	9/15/2016	2,525	65	39	65		195	27
28	Repair Hot Water Heater in D Wing	9/23/2016	2,583	66	39	65	(1)	198	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,425,112	$ 87,823		$ 87,818	$ (5)	$ 898,929	34

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

Facility Name & ID Number Momence Meadows Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 12B, Carried Forward		$ 3,425,112	$ 87,823		$ 87,818	$ (5)	$ 898,929	1
2	Replace Rooftop Unit Heat Exchanger (Hallway)	12/29/2016	3,975	102	39	102		153	2
3	Replace Rooftop Unit Heat Exchanger (Common Area)	1/5/2017	3,760	96	39	96		144	3
4	100 Gallon Hot Water Heater	2/1/2017	2,850	73	39	73		110	4
5	Replace Water Heater	5/1/2017	2,995	77	39	77		115	5
6	Replace Fire Alarm System	11/14/2017	6,349	163	39	163		244	6
7	Replace Fire Alarm Control Panel	11/14/2017	10,196	261	39	261		392	7
8									8
9	Replace Fire Alarm System	12/11/2017	6,349	81	39	81		81	9
10	Replace Antenna for Wander Guard at Front Door	1/1/2018	3,571	46	39	46		46	10
11	2 Smoke Detectors	1/3/2018	3,790	49	39	49		49	11
12	Fire Door Holders	1/3/2018	5,410	69	39	69		69	12
13	Temporary Fire Alarm Panel	1/15/2018	3,200	41	39	41		41	13
14	New Fire Alarm Control Panel (down payment)	1/12/2018	1,150	15	39	15		15	14
15	New Fire Alarm Control Panel (final payment)	1/23/2018	1,150	15	39	15		15	15
16	2 Smoke Detectors (2nd payment)	2/5/2018	3,790	49	39	49		49	16
17	Fire Door Holders (2nd payment)	2/5/2018	5,410	69	39	69		69	17
18	2 Smoke Detectors (3rd payment)	3/1/2018	3,791	49	39	49		49	18
19	Fire Door Holders (3rd payment)	3/1/2018	5,410	69	39	69		69	19
20	6 Additional Smoke Detectors & 2 Door Holders	3/1/2018	3,263	42	39	42		42	20
21	New Generator	4/23/2018	32,599	418	39	418		418	21
22	New Washer (down payment)	5/16/2018	5,628	72	39	72		72	22
23	New Washer (final payment)	5/16/2018	5,628	72	39	72		72	23
24	New Garbage Disposal	3/14/2018	2,400	31	39	31		31	24
25	Recondition Air Conditioner & Furnance	7/10/2018	3,059	39	39	39		39	25
26	Paint A, B & C Halls, main hall, lounge	9/4/2018	9,471	121	39	121		121	26
27	10 Door Alarm with Annunciator by Nursing Station	9/17/2018	7,491	96	39	96		96	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,567,797	$ 90,038		$ 90,033	$ (5)	$ 901,530	34

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

Facility Name & ID Number Momence Meadows Nursing & Rehabilitation Cente # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 699,246	$ 19,169	$ 139,849	$ 120,680	5	$ 652,116	71
72	Current Year Purchases	2,995	214	599	385	5	214	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 702,241	$ 19,383	$ 140,448	$ 121,065		$ 652,330	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)	$ 4,450,038	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 109,421	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 230,481	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 121,060	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,553,860	85	

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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.	/2019	$
13.	/2020	$
14.	/2021	$

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 Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	2,110	$ 134,305	$	2,110	$ 134,305	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		48	2,145		48	2,145	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,433	75,314		2,433	75,314	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				59,270		59,270	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray & Lab	39-2					171		171	12
13	Other (specify):									13
14	TOTAL			$	4,591	$ 211,764	$ 59,441	4,591	$ 271,205	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 Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ (44,948)	$ 221,021	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,463,293	1,463,293	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	212,694	212,694	6
7	Other Prepaid Expenses	3,151	3,151	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow Accounts		37,559	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,634,190	$ 1,937,718	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		2,671,000	14
15	Leasehold Improvements, at Historical Cost	728,797	896,797	15
16	Equipment, at Historical Cost	275,240	702,240	16
17	Accumulated Depreciation (book methods)	(344,177)	(1,553,860)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	135,438	3,716,453	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(31,478)	(3,553,232)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Replacement reserves		290,678	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 763,820	$ 3,350,076	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,398,010	$ 5,287,794	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 611,877	$ 681,262	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,458	36,458	28
29	Short-Term Notes Payable		215,416	29
30	Accrued Salaries Payable	105,028	105,028	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,847	9,847	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		17,001	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	6,858,631	6,858,631	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,621,841	$ 7,923,643	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,167,423	40
41	Bonds Payable			41
42	Deferred Compensation		(2,978,594)	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,188,829	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,621,841	$ 10,112,472	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,223,831)	$ (4,824,678)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,398,010	$ 5,287,794	48

*(See instructions.)

Facility Name & ID Number Momence Meadows Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,702,022)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,702,022)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,521,807)	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) Rounding	(2)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,521,809)	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)**	$ (5,223,831)	24 *

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

Facility Name & ID Number Momence Meadows Nursing & Rehabilitation Cent # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 4,810,873	1
2	Discounts and Allowances for all Levels	238,679	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,049,552	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	133,421	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 133,421	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	44,246	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	690	19
20	Radiology and X-Ray	194	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 45,130	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,726	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,726	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Miscellaneous Revenue	30,881	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 30,881	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,265,710	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	909,241	31
32	Health Care	2,096,502	32
33	General Administration	1,662,640	33
	B. Capital Expense		
34	Ownership	1,772,387	34
	C. Ancillary Expense		
35	Special Cost Centers	59,443	35
36	Provider Participation Fee	226,477	36
	D. Other Expenses (specify):		
37	Bad Debt Expense	60,827	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,787,517	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,521,807)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,521,807)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,202,781	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	404,327	46
47	Other-(specify)	442,444	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,049,552	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 Nursing & Rehabilitation Center, LLC # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,066	2,230	$ 93,399	$ 41.88	1
2	Assistant Director of Nursing	2,517	2,647	94,352	35.64	2
3	Registered Nurses	4,131	4,623	160,855	34.79	3
4	Licensed Practical Nurses	16,344	17,684	574,768	32.50	4
5	CNAs & Orderlies	31,691	34,457	525,537	15.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,349	7,871	93,819	11.92	9
10	Activity Assistants					10
11	Social Service Workers	2,724	2,989	61,418	20.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,701	14,026	180,295	12.85	15
16	Dishwashers					16
17	Maintenance Workers	4,194	4,362	73,222	16.79	17
18	Housekeepers	9,597	10,564	122,860	11.63	18
19	Laundry	5,323	5,840	68,262	11.69	19
20	Administrator	1,828	1,930	99,120	51.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,454	6,207	88,953	14.33	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	2,025	2,191	29,708	13.56	31
32	Other Health Care(specify)					32
33	Other(specify) admission coord	1,713	1,787	49,910	27.93	33
34	TOTAL (lines 1 - 33)	109,657	119,408	$ 2,316,478 *	$ 19.40	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	129	$ 4,512	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,470	51,457	10-3	38
39	Pharmacist Consultant	152	7,578	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	(380)	(19,000)	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	273	9,554	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,644	$ 54,101		49

C. CONTRACT NURSES

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

Facility Name & ID Number: Momence Meadows Nursing & Rehabilitation Center # 0048033 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Erickson	Administrator		$ 86,593
Sheila Storey	Administrator		1,745
Sinead O'Sullivan	Administrator		10,782
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 99,120

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	$ 12,000
Myers Services	Legal	1,500
Infinity Funding/Sedgwick	Legal	120,962
MTS Consulting	Professional	(22,569)
The Merrit Group	Professional	14,250
Various	Professional	10,522
Infinity Healthcare Mgmt	Professional/Mgmt	220,133
Empire Risk Mgmt	Mgmt	12,175
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 368,973

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 140,326
Unemployment Compensation Insurance	6,214
FICA Taxes	176,402
Employee Health Insurance	160,306
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Expense	1,064
Employee Background Checks	2,563
Pension	31,575
Employee Expense	3,408
TOTAL (agree to Schedule V, line 22, col.8)	$ 521,858

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	
IDPH	2,899
IHCA	1,239
Kankakee Health Dept	350
Secretary of State	277
Other	48
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,813

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	8,468
Seminar Expense	
Education	1,408
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,876

**See instructions.

Facility Name & ID Number **Momence Meadows Nursing & Rehabilitation Center, LLC** **#** **0048033** **Report Period Beginning:** **1/1/18** **Ending:** **12/31/18**

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 - $1,239**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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. $ **33,982** 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. $ **226,477**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

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

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

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

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