		FOR BHF USE					

LL1

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

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0048033

Facility Name: Momence Meadows Nursing 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: Aaron Mauer Telephone Number: 773-747-4506
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 1/1/20 to 12/31/20 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) ______ 3/5/2021 (Date)
(Print Name and Title) Aaron Mauer, President
(Firm Name & Address) GGM Associates, Inc., 6101 Nimtz Parkway South Bend IN 46628
(Telephone) 773-747-4506 Fax # 773-747-4725

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 Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 NA

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,159	82	4,415	24,656	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,159	82	4,415	24,656	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.25%

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 2,734

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number: Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	236,882	24,908	7,000	268,790		268,790	(3)	268,787			1
2	Food Purchase		180,877		180,877		180,877	(175)	180,702			2
3	Housekeeping	200,949	32,962		233,911		233,911		233,911			3
4	Laundry	75,234	11,295		86,529		86,529		86,529			4
5	Heat and Other Utilities			148,612	148,612		148,612	1,038	149,650			5
6	Maintenance	63,282	32,060	55,548	150,890		150,890	(845)	150,045			6
7	Other (specify):*											7
8	**TOTAL General Services**	576,347	282,102	211,160	1,069,609		1,069,609	15	1,069,624			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	1,763,412	180,981	49,542	1,993,935		1,993,935	(100,088)	1,893,847			10
10a	Therapy			282,351	282,351		282,351		282,351			10a
11	Activities	115,562	11,254		126,816		126,816		126,816			11
12	Social Services	42,938		4,669	47,607		47,607		47,607			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			7,254	7,254		7,254	(175)	7,079			15
16	**TOTAL Health Care and Programs**	1,921,912	192,235	364,816	2,478,963		2,478,963	(100,263)	2,378,700			16
	C. General Administration											
17	Administrative	110,722		3,391	114,113		114,113	27,658	141,771			17
18	Directors Fees											18
19	Professional Services			406,293	406,293		406,293	(2,688)	403,605			19
20	Dues, Fees, Subscriptions & Promotions			2,010	2,010		2,010	(3)	2,007			20
21	Clerical & General Office Expenses	130,904	32,514	292,305	455,723		455,723	(9,698)	446,025			21
22	Employee Benefits & Payroll Taxes			526,919	526,919		526,919	20,726	547,645			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,398	15,398		15,398	2,736	18,134			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			393,750	393,750		393,750	35,753	429,503			26
27	Other (specify):*											27
28	**TOTAL General Administration**	241,626	32,514	1,640,066	1,914,206		1,914,206	74,485	1,988,691			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,739,885	506,851	2,216,042	5,462,778		5,462,778	(25,763)	5,437,015			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 Reh #0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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			72,692	72,692		72,692	56,779	129,471			30
31	Amortization of Pre-Op. & Org.			16,459	16,459		16,459	18,023	34,482			31
32	Interest			3,693	3,693		3,693	139,975	143,668			32
33	Real Estate Taxes							78,215	78,215			33
34	Rent-Facility & Grounds			1,038,000	1,038,000		1,038,000	(1,035,491)	2,509			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,130,844	1,130,844		1,130,844	(742,499)	388,345			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,340	3,340		3,340		3,340			38
39	Ancillary Service Centers		94,010		94,010		94,010	(2,154)	91,856			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			208,488	208,488		208,488		208,488			42
43	Other (specify):*			110,709	110,709		110,709	(208,488)	(97,779)			43
44	TOTAL Special Cost Centers		94,010	322,537	416,547		416,547	(210,642)	205,905			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,739,885	600,861	3,669,423	7,010,169		7,010,169	(978,904)	6,031,265			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 Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	(16,049)	30		9
10	Interest and Other Investment Income	(46,631)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3)	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	(650)	21		18
19	Entertainment				19
20	Contributions	(1,400)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(208,488)	43		24
25	Fund Raising, Advertising and Promotional	(5,589)	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	(6,063)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (284,873)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(694,031)	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (694,031)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (978,904)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Momence Meadows Nursing Reh

ID# 0048033

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RP Profit	$ (49)	10	1
2	RP Profit	(175)	15	2
3	RP Profit	(2,154)	39	3
4	Misc Income - Food	(175)	2	4
5	Misc Income - Vendor Rebate	(1,435)	6	5
6	Misc Income - Med Records	(2,075)	10	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**	(6,063)		49

STATE OF ILLINOIS | Summary A

Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(3)	0	0	0	0	0	0	0	0	0	0	(3)	1
2	Food Purchase	(175)	0	0	0	0	0	0	0	0	0	0	(175)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,038	0	0	0	0	0	0	0	0	0	1,038	5
6	Maintenance	(1,435)	590	0	0	0	0	0	0	0	0	0	(845)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,613)	1,628	0	0	0	0	0	0	0	0	0	15	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	(2,124)	(97,965)	0	0	0	0	0	0	0	0	0	(100,088)	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):*	(175)	0	0	0	0	0	0	0	0	0	0	(175)	15
16	**TOTAL Health Care and Programs**	(2,299)	(97,965)	0	0	0	0	0	0	0	0	0	(100,263)	16
	C. General Administration													
17	Administrative	0	27,658	0	0	0	0	0	0	0	0	0	27,658	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(12,634)	9,946	0	0	0	0	0	0	0	0	(2,688)	19
20	Fees, Subscriptions & Promotions	0	(3)	0	0	0	0	0	0	0	0	0	(3)	20
21	Clerical & General Office Expenses	(7,639)	(2,059)	0	0	0	0	0	0	0	0	0	(9,698)	21
22	Employee Benefits & Payroll Taxes	0	20,726	0	0	0	0	0	0	0	0	0	20,726	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,736	0	0	0	0	0	0	0	0	0	2,736	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	1,100	34,653	0	0	0	0	0	0	0	0	35,753	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(7,639)	37,525	44,599	0	0	0	0	0	0	0	0	74,485	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,551)	(58,811)	44,599	0	0	0	0	0	0	0	0	(25,763)	29

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(16,049)	33	72,795	0	0	0	0	0	0	0	0	56,779	30
31	Amortization of Pre-Op. & Org.	0	0	18,023	0	0	0	0	0	0	0	0	18,023	31
32	Interest	(46,631)	2,764	183,842	0	0	0	0	0	0	0	0	139,975	32
33	Real Estate Taxes	0	0	78,215	0	0	0	0	0	0	0	0	78,215	33
34	Rent-Facility & Grounds	0	2,509	(1,038,000)	0	0	0	0	0	0	0	0	(1,035,491)	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**	(62,680)	5,306	(685,125)	0	0	0	0	0	0	0	0	(742,499)	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	(2,154)	0	0	0	0	0	0	0	0	0	0	(2,154)	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):*	(208,488)	0	0	0	0	0	0	0	0	0	0	(208,488)	43
44	**TOTAL Special Cost Centers**	(210,642)	0	0	0	0	0	0	0	0	0	0	(210,642)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(284,873)	(53,505)	(640,526)	0	0	0	0	0	0	0	0	(978,904)	45

Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	50.00	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Comsulting Co.
GELP	50.00	Belhaven Nursing & Rehab Center	Chicago	Momence Meadows Realty, LLC		Realty Co.
		Citi View Multicare Center	Cicero	United Rx		Pharmacy Co.
		Continental Nursing & Rehab Center	Chicago			
		Forest View Nursing & Rehab Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & 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		5	Heat and Other Utilities	$	Infinity Healthcare Management of IL LLC		$ 1,038	$ 1,038	1
2	V		6	Maintenance	1	Infinity Healthcare Management of IL LLC		591	590	2
3	V		10	Nursing and Medical Records	128,278	Infinity Healthcare Management of IL LLC		30,313	(97,965)	3
4	V		17	Administrative	1,077	Infinity Healthcare Management of IL LLC		28,735	27,658	4
5	V		19	Professional Services	321,392	Infinity Healthcare Management of IL LLC		308,758	(12,634)	5
6	V		20	Dues, Fees, Subscriptions & Promotior	77	Infinity Healthcare Management of IL LLC		74	(3)	6
7	V		21	Clerical & General Office Expenses	108,065	Infinity Healthcare Management of IL LLC		106,006	(2,059)	7
8	V		22	Employee Benefits & Payroll Taxes	9	Infinity Healthcare Management of IL LLC		20,735	20,726	8
9	V		24	Travel and Seminar	4,381	Infinity Healthcare Management of IL LLC		7,117	2,736	9
10	V		26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare Management of IL LLC		1,100	1,100	10
11	V		30	Depreciation		Infinity Healthcare Management of IL LLC		33	33	11
12	V		32	Interest		Infinity Healthcare Management of IL LLC		2,764	2,764	12
13	V		34	Rent-Facility & Grounds		Infinity Healthcare Management of IL LLC		2,509	2,509	13
14	Total				$ 563,280			$ 509,775	$ * (53,505)	14

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

Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	34	Rent	$ 1,038,000	Momence Meadows Realty, LLC		$	$ (1,038,000)	15
16	V	31	Amortization		Momence Meadows Realty, LLC		18,023	18,023	16
17	V	30	Depreciation		Momence Meadows Realty, LLC		72,795	72,795	17
18	V	19	Professional Services		Momence Meadows Realty, LLC		9,946	9,946	18
19	V	26	Insurance		Momence Meadows Realty, LLC		34,653	34,653	19
20	V	32	Interest		Momence Meadows Realty, LLC		183,842	183,842	20
21	V	33	Real Estate Taxes		Momence Meadows Realty, LLC		78,215	78,215	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,038,000			$ 397,474	$ * (640,526)	39

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

STATE OF ILLINOIS

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Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 [ ]

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 Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$33,987.00	8/21/13	$ 6,360,700	$ 4,959,441	10/1/36	3.4800	$ 185,780	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Credit Suisse		X	Working Capital	None	8/31/14	Various	873,300	3/14/22	4.5000	3,693	6
7												7
8												8
9	TOTAL Facility Related				$33,987.00		$ 6,360,700	$ 5,832,741			$ 189,473	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,360,700	$ 5,832,741			$ 189,473	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 28,165 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 Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	76,266	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.)	$	76,022	2
3. Under or (over) accrual (line 2 minus line 1).	$	(244)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	78,459	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.	$	78,215	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	73,616	8
2016	75,527	9
2017	75,741	10
2018	75,899	11
2019	76,022	12

FOR BHF USE ONLY

Line	Description			Line
13	FROM R. E. TAX STATEMENT FOR 2019	$		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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Momence Meadows Nursing Reh COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0048033

CONTACT PERSON REGARDING THIS REPORT Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	05-11-19-306-007	Nursing Home	$ 76,021.68	$ 76,021.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 76,021.68	$ 76,021.68

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 7/1/06

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 Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$	$ 855,478	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse Call Light			2006	26,050	668	39	668		10,020	9
10	A/C on Roof			2007	420	11	39	11		147	10
11	A/C on Roof			2007	4,424	113	39	113		1,529	11
12	Nurse Call System			2007	280	7	39	7		96	12
13	Replace Locks			2007	7,700	197	39	197		2,663	13
14	Replace Locks			2007	104	3	39	3		37	14
15	Exhaust Vent and Filter			2007	932	24	39	24		323	15
16	2007 Assets not allowed for increased capital reimbursement			2007	3,936	101	39	101		1,362	16
17	Shower Remodeling			2008	3,750	96	39	96		1,249	17
18	New Compressor on Walk In Freezer			2008	2,158	55	39	55		718	18
19	Sidewalks			2008	4,289	110	39	110		1,430	19
20	Asphalt Driveway			2008	5,775	148	39	148		1,924	20
21	Asphalt Driveway			2008	5,775	148	39	148		1,924	21
22	Shower Room Tiles			2008	9,483	243	39	243		3,160	22
23	Drywall, Ultrasteel, Concrete, Sand, etc			2008	1,129	29	39	29		377	23
24	Mortar			2008	321	8	39	8		106	24
25	Grout and Mortar			2008	83	2	39	2		27	25
26	Drywall, Mortar and Paint			2008	523	13	39	13		173	26
27	Adhesive, Mortar, etc			2008	597	15	39	15		198	27
28	Adhesive, Mortar, etc			2008	126	3	39	3		41	28
29	Misc Supplies for Shower Remodeling			2008	61	2	39	2		22	29
30	Replace Heat Exchanger in Kitchen Roof-Top			2008	2,936	75	39	75		978	30
31	2008 Assets not allowed for increased capital reimbursement			2008	3,751	96	39	96		1,249	31
32	Carpet			2009	4,480	115	39	115		1,379	32
33	Remodeling (Nurse Station, Ceiling, Lighting, Wallpaper)			2009	108,504	2,782	39	2,782		33,388	33
34	Roof Improvements			2009	3,500	90	39	90		1,078	34
35	Roof Improvements			2009	3,500	90	39	90		1,078	35
36	Building & Shower Remodeling w/ Towel Rack			2010	1,714	44	39	44		484	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 Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	Shower Remodeling & Wall Base Lining	2010	$ 1,500	$ 38	39	$ 38	$	$ 421	37
38	Fire Sprinkler	2010	1,395	36	39	36		395	38
39	Paint, Materials, and Wall Repairs	2010	7,900	203	39	203		2,229	39
40	Maintenance, Repairs, Replacements & Wages	2010	4,485	115	39	115		1,265	40
41	Materials	2010	1,482	38	39	38		418	41
42	Materials for Hot Water Valve & Labor	2010	1,814	47	39	47		513	42
43	Supplies	2010	1,536	39	39	39		432	43
44	Replace Flame Sensor/Ignitor & Labor	2010	856	22	39	22		242	44
45	Partial Billing for Cooler Replacement	2010	2,445	63	39	63		690	45
46	Repatched Walls, Resealed Gravel, Reflashed Drain	2010	1,650	42	39	42		464	46
47	New Soffit and Installed SPMB Patch	2010	950	24	39	24		267	47
48	Installed New Shingle Roof & Repaired Rotted Wood	2010	3,950	101	39	101		1,113	48
49	Remove Snow, Applied Patch to Roof, Patched 2 Holes	2010	750	19	39	19		210	49
50	Cabling for New TV Jacks ($55/jack)	2010	8,000	205	39	205		2,255	50
51	Repaired Ramp and Asphalt	2010	2,395	61	39	61		674	51
52	Replacement of Heat Exchanger	2010	1,384	35	39	35		353	52
53	Cooler Replacement	2010	2,445	63	39	63		628	53
54	2010 Assets not allowed for increased capital reimbursement	2010	7,000	179	39	179		1,972	54
55									55
56	Repair Leaks on Main Water Supply and Dishwasher	2011	1,297	33	39	33		332	56
57	Heavy Asphalt Coating to Roof	2011	950	24	39	24		242	57
58	Patching of roof and Replacement of Shingles	2011	3,000	77	39	77		770	58
59	Retrofit of light fixtures	2011	16,446	422	39	422		4,218	59
60	Stone/Steel Work and Concrete Replacement	2011	750	19	39	19		191	60
61	Stone/Steel Work and Concrete Replacement	2011	750	19	39	19		191	61
62	2011 Assets not allowed for increased capital reimbursement	2011	5,078	130	39	130		1,301	62
63									63
64	Replace heat exchanger	2012	3,775	97	39	97		872	64
65	Replace compressor in freezer	2012	3,385	87	39	87		782	65
66		2012	61,769	1,584	39	1,584	0	14,254	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,194,438	$ 81,909		$ 81,909	$ 0	$ 960,333	70

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

Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,194,438	$ 81,909		$ 81,909	$	$ 960,333	1
2	Vinyl tile	2013	1,373	35	39	35		263	2
3	Heat Exchanger	2013	2,670	68	39	68		512	3
4	Sprinkler piping & relocating	2013	48,000	1,231	39	1,231		9,232	4
5	Survey work for sprinkler piping	2013	3,600	92	39	92		691	5
6	Vinyl tiles - dining room	2013	1,375	35	39	35		264	6
7	Electrical wiring - dishwasher	2013	2,575	66	39	66		495	7
8									8
9	3 water heaters removed & new installed	2014	23,995	615	39	615		4,310	9
10	Patch wall flashings	2014	4,850	124	39	124		869	10
11	Nurses station walls / cabinets	2014	24,900	638	39	638		4,471	11
12	Patch cords & cables	2014	2,583	66	39	66		462	12
13	GAF roofing system	2014	63,400	1,626	39	1,626		11,389	13
14	Replace compressor in "C" wing	2014	3,373	86	39	86		603	14
15	Rental generator	2014	9,182	235	39	235		1,646	15
16	New door for walk-in freezer	2014	3,046	78	39	78		546	16
17	Kitchen flooring / repair leak	2014	2,253	58	39	58		406	17
18	Install booster pump	2014	1,700	44	39	44		307	18
19	Electric repairs in kitchen	2014	5,975	153	39	153		1,071	19
20	Kitchen flooring / repair leak	2014	7,550	194	39	194		1,357	20
21	Remodel & install tile in 2 rooms & bathroom	2014	1,620	42	39	42		293	21
22	Remodel & install tile in 2 rooms & bathroom	2014	2,405	62	39	62		433	22
23									23
24	Heat Exchanger	2016	3,300	85	39	85		424	24
25	Hot Water Heater for C Wing & Kitchen	2016	3,045	78	39	78		390	25
26	New Pump & Pipe for Cafeteria	2016	2,795	72	39	72		359	26
27	Installation of Hot Water Heater	2016	2,525	65	39	65		324	27
28	Repair Hot Water Heater in D Wing	2016	2,583	66	39	66		330	28
29	Replace Rooftop Unit Heat Exchanger (Hallway)	2016	3,975	102	39	102		357	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,429,086	$ 87,925		$ 87,925	$	$ 1,002,138	34

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

Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		$ 3,429,086	$ 87,925		$ 87,925	$	$ 1,002,138	1
2	Replace Rooftop Unit Heat Exchanger (Common Area)	2017	3,760	96	39	96		337	2
3	100 Gallon Hot Water Heater	2017	2,850	73	39	73		256	3
4	Replace Water Heater	2017	2,995	77	39	77		269	4
5	Replace Fire Alarm System	2017	6,349	163	39	163		570	5
6	Replace Fire Alarm Control Panel	2017	10,196	261	39	261		915	6
7	Replace Fire Alarm System	2017	6,349	163	39	163		407	7
8									8
9	Replace Antenna for Wander Guard at Front Door	2018	3,571	92	39	92		229	9
10	2 Smoke Detectors	2018	3,790	97	39	97		243	10
11	Fire Door Holders	2018	5,410	139	39	139		346	11
12	Temporary Fire Alarm Panel	2018	3,200	82	39	82		205	12
13	New Fire Alarm Control Panel (down payment)	2018	1,150	29	39	29		74	13
14	New Fire Alarm Control Panel (final payment)	2018	1,150	29	39	29		74	14
15	2 Smoke Detectors (2nd payment)	2018	3,790	97	39	97		243	15
16	Fire Door Holders (2nd payment)	2018	5,410	139	39	139		346	16
17	2 Smoke Detectors (3rd payment)	2018	3,791	97	39	97		243	17
18	Fire Door Holders (3rd payment)	2018	5,410	139	39	139		346	18
19	6 Additional Smoke Detectors & 2 Door Holders	2018	3,263	84	39	84		209	19
20	New Generator	2018	32,599	836	39	836		2,090	20
21	New Washer (down payment)	2018	5,628	144	39	144		361	21
22	New Washer (final payment)	2018	5,628	144	39	144		361	22
23	New Garbage Disposal	2018	2,400	62	39	62		154	23
24	Recondition Air Conditioner & Furnance	2018	3,059	78	39	78		196	24
25	Paint A, B & C Halls, main hall, lounge	2018	9,471	243	39	243		607	25
26	10 Door Alarm with Annunciator by Nursing Station	2018	7,491	192	39	192		480	26
27									27
28	Rewire Room 104	2019	3,200	82	39	82		82	28
29	Repaint C Hall Walls	2019	5,300	136	39	136		222	29
30	Install Smoke Detectors on Wings A, B, C & D	2019	5,932	152	39	152		254	30
31	New Mixing Valves, Back Flows, Copper fittings for Kitchen & La	2019	6,220	159	39	159		279	31
32	Preventive Maintenance Performed on HVAC Unit	2019	3,241	83	39	83		132	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,591,689	$ 92,095		$ 92,095	$	$ 1,012,668	34

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

Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12C, Carried Forward		$ 3,591,689	$ 92,095		$ 92,095	$	$ 1,012,668	1
2	Repair Leaking Water Pipe in Boiler Room	2019	1,248	32	39	32		16	2
3	Repair Leaking Water Pipe in Boiler Room; Install Expansion Tai	2019	1,245	32	39	32		16	3
4	Natural Gas Water Heater	2019	4,638	119	39	119		50	4
5	New Water Heater for Laundry Room	2019	2,045	52	39	52		22	5
6	Rodding Drain Pipe for Toilet in Room C-106; Rodding Pipe for C	2019	1,285	33	39	33		14	6
7	Completion of IDPH Violations;	2019	6,220	159	39	159		13	7
8	Install Quad Outlets in Patient Rooms in A Wing	2019	2,700	69	39	69		6	8
9	Install Quad Outlets in Patient Rooms in D Wing	2019	2,700	69	39	69		6	9
10									10
11									11
12	Replace Circuit Breakers in Rooms 212 & 214. Install New Heater	2020	3,675	94	39	94		94	12
13	Replacement of Phone System	2020	5,328	137	39	137		137	13
14	Repairs to Flat Roof	2020	2,775	71	39	42	(30)	71	14
15	New Rheem Water Heater	2020	4,500	115	39	58	(58)	115	15
16	New Mansard Shingle Roof	2020	9,800	251	39	126	(126)	251	16
17	New Kitchen Grease Trap	2020	3,975	102	39	51	(51)	102	17
18	Repair Faulty Drain Piping in Mechanical Room for New Kitchen	2020	381	10	39	3	(7)	10	18
19	Repair Water Leak in Mechanical Room	2020	571	15	39	5	(10)	15	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,644,775	$ 93,456		$ 93,176	$ (280)	$ 1,013,605	34

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

Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 194,636	$ 34,543	$ 34,543	$	5	$ 130,010	71
72	Current Year Purchases	17,521	17,521	1,752	(15,769)	5	17,521	72
73	Fully Depreciated Assets	591,994				5	591,994	73
74								74
75	TOTALS	$ 804,151	$ 52,064	$ 36,295	$ (15,769)		$ 739,525	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)	$ 4,628,926	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 145,520	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 129,471	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (16,049)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,753,130	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

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.	/2021	$
13.	/2022	$
14.	/2023	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

** <u>This amount plus any amortization of lease expense must agree with page 4, line 34.</u>

Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	1,989	$ 133,036	$	1,989	$ 133,036	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		6	21,181		6	21,181	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,495	128,106		2,495	128,106	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				89,298		89,298	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					1,738		1,738	12
13	Other (specify): Lab	39-2					2,973		2,973	13
14	TOTAL			$	4,491	$ 282,323	$ 94,010	4,491	$ 376,333	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 Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (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	$ (113,330)	$ 193,624	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,292,364	1,292,364	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	235,331	235,331	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		46,042	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,414,365	$ 1,767,361	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		168,000	14
15	Leasehold Improvements, at Historical Cost	805,775	805,775	15
16	Equipment, at Historical Cost	377,151	3,048,151	16
17	Accumulated Depreciation (book methods)	(471,304)	(1,399,577)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	176,352	446,692	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(62,127)	(323,465)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		305,112	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 825,847	$ 3,230,688	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,240,212	$ 4,998,049	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 539,071	$ 617,128	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,602	38,602	28
29	Short-Term Notes Payable	618,500	857,496	29
30	Accrued Salaries Payable	156,146	156,146	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,394	16,394	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,368,713	$ 1,685,766	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,720,445	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)**	$	$ 4,720,445	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,368,713	$ 6,406,211	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 871,499	$ (1,408,162)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,240,212	$ 4,998,049	48

*(See instructions.)

Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 744,561	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 744,561	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	126,938	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 Error**	(1)	15
16	Other (describe) **Rounding**	1	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 126,938	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)**	$ 871,499	24 *

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

Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,156,779	1
2	Discounts and Allowances for all Levels	20,414	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,177,193	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	48,010	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 48,010	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	845,401	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	2,581	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	13,598	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 861,580	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	46,631	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 46,631	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Income	3,693	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,693	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,137,107	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,069,609	31
32	Health Care	2,478,963	32
33	General Administration	1,914,206	33
	B. Capital Expense		
34	Ownership	1,130,844	34
	C. Ancillary Expense		
35	Special Cost Centers	416,547	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,010,169	40
41	**Income before Income Taxes (line 30 minus line 40)****	126,938	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 126,938	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,192,382	44
45	Private Pay - Net Inpatient Revenue	32,317	45
46	Medicare - Net Inpatient Revenue	1,536,494	46
47	Other-(specify) NET PATIENT REVENUE	416,000	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,177,193	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 Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	2,056	2,160	$ 98,417	$ 45.56	1
2	Assistant Director of Nursing	3,374	3,562	139,064	39.04	2
3	Registered Nurses	4,060	4,880	204,400	41.89	3
4	Licensed Practical Nurses	16,150	19,762	669,708	33.89	4
5	CNAs & Orderlies	28,940	35,073	580,531	16.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,154	6,790	115,562	17.02	10
11	Social Service Workers	1,947	2,051	42,938	20.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,936	14,382	236,882	16.47	15
16	Dishwashers					16
17	Maintenance Workers	2,622	3,019	63,282	20.96	17
18	Housekeepers	9,909	10,995	169,771	15.44	18
19	Laundry	4,775	5,294	75,234	14.21	19
20	Administrator	1,896	2,109	110,722	52.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,353	6,956	130,904	18.82	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	3,147	3,361	102,470	30.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,319	120,394	$ 2,739,885 *	$ 22.76	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	146	$ 7,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	598	31,938	10-3	38
39	Pharmacist Consultant	145	7,254	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	70	4,539	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	959	$ 50,731		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	283	17,604	10-2	52
53	TOTAL (lines 50 - 52)	283	$ 17,604		53

Facility Name & ID Number: Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Uzelac, Jillian M	Administrators	0	$ 7,066
O'Sullivan, Sinead	Administrators	0	103,656
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 110,722

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
Infinity Healthcare Management of Il	Management fees	$ 312,069
Global Healthcare Apex	Professional fees	3,517
Empire Risk Management Services, I	Professional fees	12,000
Genex Services, LLC.	Professional fees	124
Global Fiscal Midwest LLC	Professional fees	4,762
Infinity Healthcare Management of Il	Professional fees	1,075
Precise Healthcare Management	Professional fees	12,207
Professional Search Network	Professional fees	12,450
	Professional fees	
USA Risk Management Inc	Professional fees	554
See attatched schedule		47,535
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 406,293

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,071
Unemployment Compensation Insurance	20,874
FICA Taxes	221,742
Employee Health Insurance	209,183
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Unform	3,747
Other employee benefits	9,129
Pension	24,850
Employee backround check	1,049
TOTAL (agree to Schedule V, line 22, col.8)	$ 547,645

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	$ 1,327
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Patient Background Checks	
Kankakee county health dept	400
Clia Laborotory	180
Other Licenses and dues	100
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,007

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Travel Reimbursement	5,520
In-State Travel	
Travel Reimbursement	2,736
Travel Reimbursement	9,261
Seminar Expense	
Education and Seminars	617
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,134

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
Premier Destine In	Professional fees	704
People Powered LLC	Professional fees	2,000
Infinity H Funding	Professional fees	423
Guide One Insurance	Legal fees	25,000
Infinity Funding / Sedgwick	Legal fees	7,890
Infinity Healthcare Management of Il	Legal fees	392
Klauke Law Group LLC	Legal fees	26
McGuire Woods	Legal fees	2,099
GGm	Accounting Fees	6,000
Johnson and Goldburg	Accounting Fees	3,000
See attatched schedule		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 47,535

Facility Name & ID Number Momence Meadows Nursing Reh # 0048033 Report Period Beginning: 1/1/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **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 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **42,884** Line **10**

(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. $ **208,488**
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. $ ____

(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.