FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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 & REHAB

Address: 500 SOUTH WALNUT STREET (Number) MOMENCE (City) 60954 (Zip Code)

County: KANKAKEE

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: DANIEL S. GAAFAR **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 1/1/10 to 12/31/10 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) MOISHE GUBIN
(Title) MANAGER

Paid Preparer

(Signed) SEE ACCOUNTANTS REPORT ATTACHED (Date)
(Print Name and Title) DANIEL S. GAAFAR, PARTNER
(Firm Name & Address) BRADLEY & ASSOCIATES, INC., 201 S. CAPITOL AVE, STE 910, 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	31,049	4,868	4,785	40,702	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,049	4,868	4,785	40,702	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.65%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/1/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/06 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 3,817

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: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REH # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	173,513	21,853	15,000	210,366		210,366	(4,611)	205,755			1
2	Food Purchase		180,046		180,046		180,046		180,046			2
3	Housekeeping	156,473	27,391		183,864		183,864		183,864			3
4	Laundry	108,401	15,515		123,916		123,916		123,916			4
5	Heat and Other Utilities			156,130	156,130		156,130		156,130			5
6	Maintenance	30,712	9,366	28,613	68,691		68,691	(1,134)	67,557			6
7	Other (specify):*											7
8	TOTAL General Services	469,099	254,171	199,743	923,013		923,013	(5,745)	917,268			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	2,129,266	187,527	25,800	2,342,593		2,342,593	10,350	2,352,943			10
10a	Therapy			393,486	393,486		393,486		393,486			10a
11	Activities	83,443	21,967		105,410		105,410		105,410			11
12	Social Services	60,892		5,258	66,150		66,150		66,150			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consultant			22,749	22,749		22,749		22,749			15
16	TOTAL Health Care and Programs	2,273,601	209,494	455,693	2,938,788		2,938,788	10,350	2,949,138			16
	C. General Administration											
17	Administrative	87,661			87,661		87,661		87,661			17
18	Directors Fees											18
19	Professional Services			229,986	229,986		229,986	(210,578)	19,408			19
20	Dues, Fees, Subscriptions & Promotions			777	777		777	446	1,223			20
21	Clerical & General Office Expenses	158,314	62,914	22,064	243,292		243,292	61,938	305,230			21
22	Employee Benefits & Payroll Taxes			607,728	607,728		607,728	22,002	629,730			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,981	3,981		3,981	270	4,251			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			99,869	99,869		99,869	54,081	153,950			26
27	Other (specify):*											27
28	TOTAL General Administration	245,975	62,914	964,405	1,273,294		1,273,294	(71,841)	1,201,453			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,988,675	526,579	1,619,841	5,135,095		5,135,095	(67,236)	5,067,859			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 & REHAB #0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

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			33,495	33,495		33,495	45,830	79,325			30
31	Amortization of Pre-Op. & Org.			2,825	2,825		2,825	324,535	327,360			31
32	Interest			107,810	107,810		107,810	370,359	478,169			32
33	Real Estate Taxes							61,018	61,018			33
34	Rent-Facility & Grounds			1,038,000	1,038,000		1,038,000	(1,037,354)	646			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,182,130	1,182,130		1,182,130	(235,612)	946,518			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		263,703		263,703		263,703		263,703			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,650	76,650		76,650		76,650			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		263,703	76,650	340,353		340,353		340,353			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,988,675	790,282	2,878,621	6,657,578		6,657,578	(302,848)	6,354,730			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	(13,881)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	107	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	2,096	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	(24,605)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (36,283)		$	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)	(266,565)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (266,565)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (302,848)		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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
MOMENCE MEADOWS NURSING & REHAB
ID# 0048033
Report Period Beginning: 1/1/10
Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ (1,191)	6	1
2	Misc. Revenue	(21,614)	21	2
3	Interest Income	(479)	32	3
4	Medical Records Income	(147)	10	4
5	Interest & Other Investment Income	(1,174)	32	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(24,605)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB **#** 0048033 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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	107	(4,718)	0	0	0	0	0	0	0	0	0	(4,611)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,191)	57	0	0	0	0	0	0	0	0	0	(1,134)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,084)	(4,661)	0	0	0	0	0	0	0	0	0	(5,745)	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	(147)	10,497	0	0	0	0	0	0	0	0	0	10,350	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(147)	10,497	0	0	0	0	0	0	0	0	0	10,350	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(215,578)	5,000	0	0	0	0	0	0	0	0	(210,578)	19
20	Fees, Subscriptions & Promotions	0	446	0	0	0	0	0	0	0	0	0	446	20
21	Clerical & General Office Expenses	(19,518)	81,346	110	0	0	0	0	0	0	0	0	61,938	21
22	Employee Benefits & Payroll Taxes	0	22,002	0	0	0	0	0	0	0	0	0	22,002	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	270	0	0	0	0	0	0	0	0	0	270	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	54,081	0	0	0	0	0	0	0	0	0	54,081	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(19,518)	(57,433)	5,110	0	0	0	0	0	0	0	0	(71,841)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,749)	(51,597)	5,110	0	0	0	0	0	0	0	0	(67,236)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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	(13,881)	0	59,711	0	0	0	0	0	0	0	0	45,830	30
31	Amortization of Pre-Op. & Org.	0	0	324,535	0	0	0	0	0	0	0	0	324,535	31
32	Interest	(1,653)	0	372,012	0	0	0	0	0	0	0	0	370,359	32
33	Real Estate Taxes	0	0	61,018	0	0	0	0	0	0	0	0	61,018	33
34	Rent-Facility & Grounds	0	(1,037,354)	0	0	0	0	0	0	0	0	0	(1,037,354)	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	(15,534)	(1,037,354)	817,276	0	0	0	0	0	0	0	0	(235,612)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(36,283)	(1,088,951)	822,386	0	0	0	0	0	0	0	0	(302,848)	45

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHMENT #1						

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	10	NURSING	$ 25,200	INFINITY HEALTHCARE MANAGEMENT		$ 35,697	$ 10,497	1
2	V	1	DIETARY	15,000	INFINITY HEALTHCARE MANAGEMENT		10,282	(4,718)	2
3	V	21	OFFICE EXPENSE	26,621	INFINITY HEALTHCARE MANAGEMENT		7,292	(19,329)	3
4	V	19	PROFESSIONAL SERVICES	216,000	INFINITY HEALTHCARE MANAGEMENT		422	(215,578)	4
5	V	22	EMPLOYEE EXPENSE	3,734	INFINITY HEALTHCARE MANAGEMENT		25,736	22,002	5
6	V	24	EDUCATION	372	INFINITY HEALTHCARE MANAGEMENT		642	270	6
7	V	6	MAINTENANCE		INFINITY HEALTHCARE MANAGEMENT		57	57	7
8	V	21	OFFICE EXPENSE		INFINITY HEALTHCARE MANAGEMENT		100,675	100,675	8
9	V	26	INSURANCE		INFINITY HEALTHCARE MANAGEMENT		395	395	9
10	V	34	RENT	1,038,000	MOMENCE MEADOWS REALTY LLC		646	(1,037,354)	10
11	V	20	CLASSIFIED ADV.		INFINITY HEALTHCARE MANAGEMENT		196	196	11
12	V	20	FILING FEES		MOMENCE MEADOWS REALTY LLC		250	250	12
13	V	26	PROPERTY INSURANCE		MOMENCE MEADOWS REALTY LLC		53,686	53,686	13
14	Total			$ 1,324,927			$ 235,976	$ * (1,088,951)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	INTEREST EXPENSE	$	MOMENCE MEADOWS REALTY LLC		$ 372,012	$ 372,012	15
16	V	33	PROPERTY TAXES		MOMENCE MEADOWS REALTY LLC		61,018	61,018	16
17	V	30	DEPRECIATION		MOMENCE MEADOWS REALTY LLC		59,711	59,711	17
18	V	31	AMORTIZATION		MOMENCE MEADOWS REALTY LLC		324,535	324,535	18
19	V	19	PROFESSIONAL FEES		MOMENCE MEADOWS REALTY LLC		5,000	5,000	19
20	V	21	OFFICE EXPENSE		MOMENCE MEADOWS REALTY LLC		110	110	20
21	V								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			$			$ 822,386	$ * 822,386	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

ATTACHMENT #1

OWNERS

NAME	OWNERSHIP %
MICHAEL BLISKO	31.580%
MOISHE GUBIN	33.680%
BERNARD STEINBURG	3.160%
A&F GENERAL PARTNERSHIP	31.580%
	100.000%

OTHER RELATED BUSINESS ENTITIES

NAME	CITY	TYPE OF BUSINESS
INFINITY HEALTHCARE MANAGEMENT	HILLSIDE, ILLINOIS	MANAGEMENT CO.

NOTE: INFINITY HEALTHCARE MANAGEMENT IS OWNED BY MOISHE GUBIN AND MICHAEL BLISKO.

Facility Name & ID Number MOMENCE MEADOWS NURSING & REI # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REH # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Prudential		X	HUD Mortgage	$39,328.00	7/25/01	$ 6,526,000	$ 6,250,169	7/25/36	5.9000	$ 372,012	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Midwest Bank & Trust Co.		X	Working Capital	None	7/11/06	2,000,000	1,100,000	6/7/10	5.5000	107,810	6
7												7
8												8
9	TOTAL Facility Related				$39,328.00		$ 8,526,000	$ 7,350,169			$ 479,822	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,526,000	$ 7,350,169			$ 479,822	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 37,382	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.)		$ 41,764	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,382	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 56,636	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.		$ 61,018	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	61,485	8
	2006	61,732	9
	2007	62,998	10
	2008	41,265	11
	2009	41,764	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MOMENCE MEADOWS NURSING & REHAB 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-11-19-306-007	NURSING HOME	$ 41,764.08	$ 41,764.08
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 41,764.08	$ 41,764.08

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,850 B. General Construction Type: Exterior BRICK Frame CONCRETE/STEEL Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 312,704
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 20,848
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	NURSING HOME		7/1/2006	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140		2006		$ 2,000,000	$ 51,282	39	$ 51,282	$	$ 232,051	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse Call Light			11/30/2006	26,050	668	39	668	0	3,340	9
10	A/C on Roof			1/20/2007	420	11	39	11	0	43	10
11	A/C on Roof			2/16/2007	4,424	113	39	113	(0)	434	11
12	Refrigerator			4/27/2007	537	14	39	14	0	51	12
13	Nurse Call System			5/30/2007	280	7	39	7	(0)	25	13
14	laundry			9/11/2007	1,967	50	39	50	(0)	167	14
15	Freezer			9/20/2007	1,432	37	39	37	0	120	15
16	Replace Locks			11/15/2007	7,700	197	39	197	(0)	624	16
17	Replace Locks			11/15/2007	104	3	39	3	0	9	17
18	Exhaust Vent and Filter			11/27/2007	932	24	39	24	0	74	18
19	Shower Remodeling			6/20/2008	3,750	96	39	96	(0)	248	19
20	Shower Remodeling			7/29/2008	3,750	96	39	96	(0)	240	20
21	New Compressor on Walk In Freezer			1/24/2008	2,158	55	39	55	(0)	165	21
22	Sidewalks			3/10/2008	4,289	110	39	110	0	312	22
23	Asphalt Driveway			4/9/2008	5,775	148	39	148	(0)	407	23
24	Asphalt Driveway			4/22/2008	5,775	148	39	148	(0)	407	24
25	Shower Room Tiles			4/30/2008	9,483	243	39	243	(0)	668	25
26	Drywall, Ultrasteel, Concrete, Sand, etc			5/31/2008	1,129	29	39	29	0	77	26
27	Mortar			6/8/2008	321	8	39	8	(0)	21	27
28	Grout and Mortar			6/20/2008	83	2	39	2	(0)	5	28
29	Drywall, Mortar and Paint			7/1/2008	523	13	39	13	(0)	33	29
30	Adhesive, Mortar, etc			7/5/2008	597	15	39	15	(0)	38	30
31	Adhesive, Mortar, etc			7/15/2008	126	3	39	3	(0)	8	31
32	Misc Supplies for Shower Remodeling			7/31/2008	61	2	39	2	0	5	32
33	Replace Heat Exchanger in Kitchen Roof-Top			12/11/2008	2,936	75	39	75	(0)	156	33
34	Carpet			12/29/2009	4,480	115	39	115	0	125	34
35	Remodeling (Nurse Station, Ceiling, Lighting, Wallpaper)			2/16/2009	108,504	2,782	39	2,782	(0)	5,332	35
36											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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Roof Improvements	4/5/2009	$ 3,500	$ 90	39	$ 90	$	$ 157	37
38	Roof Improvements	12/21/2009	3,500	90	39	90		97	38
39	Building & Shower Remodeling w/ Towel Rack	11/2/2010	1,714	44	39	7	(37)	7	39
40	Shower Remodeling & Wall Base Lining	11/17/2010	1,500	38	39	6	(32)	6	40
41	Fire Sprinkler	12/24/2010	1,395	36	39	3	(33)	3	41
42	Paint, Materials, and Wall Repairs	11/23/2010	7,900	203	39	34	(169)	34	42
43	Maintenance, Repairs, Replacements & Wages	11/23/2010	4,485	115	39	19	(96)	19	43
44	Materials	12/9/2010	1,482	38	39	3	(35)	3	44
45	Materials for Hot Water Valve & Labor	3/30/2010	1,814	47	39	39	(8)	39	45
46	Supplies	11/18/2010	1,536	39	39	7	(32)	7	46
47	Replace Flame Sensor/Ignitor & Labor	12/1/2010	856	22	39	2	(20)	2	47
48	Partial Billing for Cooler Replacement	12/8/2010	2,445	63	39	5	(58)	5	48
49	Repatched Walls, Resealed Gravel, Reflashed Drain	3/19/2010	1,650	42	39	35	(7)	35	49
50	New Soffit and Installed SPMB Patch	4/12/2010	950	24	39	18	(6)	18	50
51	Installed New Shingle Roof & Repaired Rotted Wood	11/22/2010	3,950	101	39	17	(84)	17	51
52	Remove Snow, Applied Patch to Roof, Patched 2 Holes	12/27/2010	750	19	39	2	(17)	2	52
53	Cabling for New TV Jacks ($55/jack)	5/24/2010	8,000	205	39	120	(85)	120	53
54	Satellite TV System with 32 Channels	5/24/2010	7,000	179	39	105	(74)	105	54
55	Repaired Ramp and Asphalt	11/18/2010	2,395	61	39	10	(51)	10	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,254,407	$ 57,806		$ 56,958	$ (848)	$ 245,871	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 124,704	$ 21,613	$ 21,613	$	various	$ 84,294	71
72	Current Year Purchases	14,008	13,788	754	(13,034)	various	754	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 138,712	$ 35,401	$ 22,367	$ (13,034)		$ 85,048	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	2,493,119	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	93,207	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	79,325	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(13,882)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	330,919	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 196,496	$		$ 196,496	1
2	Licensed Speech and Language Development Therapist		hrs			18,576			18,576	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			178,414			178,414	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				247,073		247,073	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Radiology & Lab						16,630		16,630	12
13	Other (specify):									13
14	TOTAL			$		$ 393,486	$ 263,703		$ 657,189	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (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	$ 18,836	$ 249,099	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,335,894	2,684,764	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	93,971	93,971	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,448,701	$ 3,027,834	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		2,000,000	14
15	Leasehold Improvements, at Historical Cost	254,408	254,408	15
16	Equipment, at Historical Cost	79,712	138,712	16
17	Accumulated Depreciation (book methods)	(74,578)	(343,277)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	42,364	312,704	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(12,003)	(93,106)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Goodwill/Escrow		3,146,510	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 289,903	$ 5,515,951	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,738,604	$ 8,543,785	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 441,445	$ 505,512	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	338,311	338,311	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 779,756	$ 843,823	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,250,000	7,171,849	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to other facilities	928,320	928,320	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,178,320	$ 8,100,169	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,958,076	$ 8,943,992	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (219,472)	$ (400,207)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,738,604	$ 8,543,785	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (285,603)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (285,603)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	284,125	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	(217,994)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 66,131	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)**	$ (219,472)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,444,058	1
2	Discounts and Allowances for all Levels	(547,404)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,896,654	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	713,117	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 713,117	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	263,037	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,538	19
20	Radiology and X-Ray	708	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 304,283	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,174	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,174	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	1,191	28
28a	Miscellaneous	25,284	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,475	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,941,703	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	923,011	31
32	Health Care	2,938,787	32
33	General Administration	1,273,297	33
	B. Capital Expense		
34	Ownership	1,182,130	34
	C. Ancillary Expense		
35	Special Cost Centers	263,703	35
36	Provider Participation Fee	76,650	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,657,578	40
41	**Income before Income Taxes (line 30 minus line 40)****	284,125	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 284,125	43

* **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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,784	1,872	$ 74,160	$ 39.62	1
2	Assistant Director of Nursing	5,348	6,343	192,560	30.36	2
3	Registered Nurses	6,088	6,727	212,711	31.62	3
4	Licensed Practical Nurses	27,445	31,021	789,654	25.46	4
5	CNAs & Orderlies	75,649	82,963	827,748	9.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	8,013	8,964	83,443	9.31	9
10	Activity Assistants					10
11	Social Service Workers	3,071	3,469	60,892	17.55	11
12	Dietician	15,779	17,605	173,513	9.86	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,994	2,165	30,712	14.19	17
18	Housekeepers	13,712	15,025	156,473	10.41	18
19	Laundry	10,567	11,978	108,401	9.05	19
20	Administrator	1,992	2,160	87,661	40.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,396	10,410	158,314	15.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,891	2,203	32,433	14.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,729	202,905	$ 2,988,675 *	$ 14.73	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	429	$ 15,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	516	25,800	10-3	38
39	Pharmacist Consultant	455	22,749	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	150	5,258	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,550	$ 68,807		49

C. CONTRACT NURSES

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

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Michael Wartman	Administrator	0%	87,661
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,661

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
		$
Misc. Legal	Legal	1,456
Johnson Goldberg	Accounting	3,000
Bradley & Associates	Accounting	8,280
Infinity Healthcare Mang.	Management Co.	217,250
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 229,986

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,460
Unemployment Compensation Insurance	72,108
FICA Taxes	228,743
Employee Health Insurance	148,982
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	1,278
Pension Expense	20,535
Emplyee Expense	40,624
TOTAL (agree to Schedule V, line 22, col.8)	$ 629,730

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	446
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Patient Background Checks	
Secretary of State	527
Laboratory User Fees	150
Commerce of Chambers	100
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,223

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel & Entertainment	642
Mileage	2,503
Seminar Expense	
Education	1,106
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,251

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/10 Ending: 12/31/10

XX. GENERAL INFORMATION:

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

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

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **75,820** 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. $ **76,650**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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 of Schedule V? **N/A**

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