		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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0048033

Facility Name: MOMENCE MEADOWS NURSING & REHAB

Address: 500 SOUTH WALNUT (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 1/1/2011 to 12/31/2011 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 ACCOUNTANT'S 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: 1/1/2011 Ending: 12/31/2011

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	33,916	437	4,848	39,201	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,916	437	4,848	39,201	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.71%

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 4,324

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

* 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: 1/1/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	180,002	20,675	15,000	215,677		215,677	(6,633)	209,044			1
2	Food Purchase		186,321		186,321		186,321	(112)	186,209			2
3	Housekeeping	184,561	25,124		209,685		209,685		209,685			3
4	Laundry	72,810	14,378		87,188		87,188		87,188			4
5	Heat and Other Utilities			141,291	141,291		141,291	369	141,660			5
6	Maintenance	32,713	8,125	31,487	72,325		72,325	(680)	71,645			6
7	Other (specify):*											7
8	TOTAL General Services	470,086	254,623	187,778	912,487		912,487	(7,056)	905,431			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	2,140,738	182,492	32,250	2,355,480		2,355,480	10,718	2,366,198			10
10a	Therapy			420,298	420,298		420,298		420,298			10a
11	Activities	85,176	16,989		102,165		102,165		102,165			11
12	Social Services	57,214		6,555	63,769		63,769		63,769			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult.			8,189	8,189		8,189		8,189			15
16	TOTAL Health Care and Programs	2,283,128	199,481	475,692	2,958,301		2,958,301	10,718	2,969,019			16
	C. General Administration											
17	Administrative	87,086			87,086		87,086		87,086			17
18	Directors Fees											18
19	Professional Services			246,890	246,890		246,890	(234,278)	12,612			19
20	Dues, Fees, Subscriptions & Promotions			5,382	5,382		5,382	25	5,407			20
21	Clerical & General Office Expenses	176,405	68,117	20,483	265,005		265,005	116,294	381,299			21
22	Employee Benefits & Payroll Taxes			599,332	599,332		599,332	5,302	604,634			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,893	2,893		2,893	433	3,326			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			98,992	98,992		98,992	43,088	142,080			26
27	Other (specify):*											27
28	TOTAL General Administration	263,491	68,117	973,972	1,305,580		1,305,580	(69,136)	1,236,444			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,016,705	522,221	1,637,442	5,176,368		5,176,368	(65,474)	5,110,894			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: 1/1/2011 Ending: 12/31/2011

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			39,177	39,177		39,177	39,160	78,337			30
31	Amortization of Pre-Op. & Org.			2,825	2,825		2,825	324,540	327,365			31
32	Interest			74,326	74,326		74,326	311,345	385,671			32
33	Real Estate Taxes							41,764	41,764			33
34	Rent-Facility & Grounds			1,038,000	1,038,000		1,038,000	(1,026,995)	11,005			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			2,904	2,904		2,904		2,904			36
37	TOTAL Ownership			1,157,232	1,157,232		1,157,232	(310,186)	847,046			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		231,290		231,290		231,290		231,290			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		231,290	76,650	307,940		307,940		307,940			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,016,705	753,511	2,871,324	6,641,540		6,641,540	(375,660)	6,265,880			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: 1/1/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(20,552)	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	(10)	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	(2,394)	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	(36,709)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (59,665)		$	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)	(315,995)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (315,995)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (375,660)		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

MOMENCE MEADOWS NURSING & REHAB

ID# 0048033

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	INTEREST INCOME	$ (1,674)	32	1
2	VENDING INCOME	(767)	6	2
3	MISC. INCOME - MEDICAL RECORDS	(650)	10	3
4	MISC. INCOME - OFFICE EXPENSES	(29,807)	21	4
5	MISC. INCOME - EMPLOYEE BENEFITS	(476)	22	5
6	MISC. INCOME - SOC. SEC. INTEREST	(3,335)	32	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**	(36,709)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(10)	(6,623)	0	0	0	0	0	0	0	0	0	(6,633)	1
2	Food Purchase	0	(112)	0	0	0	0	0	0	0	0	0	(112)	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	369	0	0	0	0	0	0	0	0	0	369	5
6	Maintenance	(767)	87	0	0	0	0	0	0	0	0	0	(680)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(777)	(6,279)	0	0	0	0	0	0	0	0	0	(7,056)	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	(650)	11,368	0	0	0	0	0	0	0	0	0	10,718	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**	(650)	11,368	0	0	0	0	0	0	0	0	0	10,718	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	(234,278)	0	0	0	0	0	0	0	0	0	(234,278)	19
20	Fees, Subscriptions & Promotions	0	25	0	0	0	0	0	0	0	0	0	25	20
21	Clerical & General Office Expenses	(32,201)	148,485	10	0	0	0	0	0	0	0	0	116,294	21
22	Employee Benefits & Payroll Taxes	(476)	5,778	0	0	0	0	0	0	0	0	0	5,302	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	433	0	0	0	0	0	0	0	0	0	433	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	377	42,711	0	0	0	0	0	0	0	0	43,088	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(32,677)	(79,180)	42,721	0	0	0	0	0	0	0	0	(69,136)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,104)	(74,091)	42,721	0	0	0	0	0	0	0	0	(65,474)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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	(20,552)	0	59,712	0	0	0	0	0	0	0	0	39,160	30
31	Amortization of Pre-Op. & Org.	0	0	324,540	0	0	0	0	0	0	0	0	324,540	31
32	Interest	(5,009)	0	316,354	0	0	0	0	0	0	0	0	311,345	32
33	Real Estate Taxes	0	0	41,764	0	0	0	0	0	0	0	0	41,764	33
34	Rent-Facility & Grounds	0	11,005	(1,038,000)	0	0	0	0	0	0	0	0	(1,026,995)	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**	(25,561)	11,005	(295,630)	0	0	0	0	0	0	0	0	(310,186)	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)**	(59,665)	(63,086)	(252,909)	0	0	0	0	0	0	0	0	(375,660)	45

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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
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	1	DIETARY	$ 15,000	INFINITY HEALTHCARE MANAGEMENT		$ 8,377	$ (6,623)	1
2	V	2	FOOD	112	INFINITY HEALTHCARE MANAGEMENT			(112)	2
3	V	5	UTILITIES	73	INFINITY HEALTHCARE MANAGEMENT		442	369	3
4	V	6	MAINTENANCE	600	INFINITY HEALTHCARE MANAGEMENT		687	87	4
5	V	10	NURSING	25,200	INFINITY HEALTHCARE MANAGEMENT		36,568	11,368	5
6	V	19	PROFESSIONAL SVCS	228,000	INFINITY HEALTHCARE MANAGEMENT		222	(227,778)	6
7	V	21	OFFICE EXPENSE	28,515	INFINITY HEALTHCARE MANAGEMENT		177,000	148,485	7
8	V	22	EMPLOYEE BENEFITS	2,601	INFINITY HEALTHCARE MANAGEMENT		8,379	5,778	8
9	V	24	TRAVEL/SEMINAR/EDUC		INFINITY HEALTHCARE MANAGEMENT		433	433	9
10	V	26	INSURANCE		INFINITY HEALTHCARE MANAGEMENT		377	377	10
11	V	34	RENT		INFINITY HEALTHCARE MANAGEMENT		11,005	11,005	11
12	V	19	PROFESSIONAL SVCS		MOMENCE MEADOWS REALTY LLC		(6,500)	(6,500)	12
13	V	20	FILING FEES		MOMENCE MEADOWS REALTY LLC		25	25	13
14	Total			$ 300,101			$ 237,015	$ * (63,086)	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: 1/1/2011 Ending: 12/31/2011

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	21	OFFICE EXPENSES	$	MOMENCE MEADOWS REALTY LLC		$ 10	$ 10	15
16	V	26	INSURANCE		MOMENCE MEADOWS REALTY LLC		42,711	42,711	16
17	V	30	DEPRECIATION		MOMENCE MEADOWS REALTY LLC		59,712	59,712	17
18	V	32	INTEREST	48,845	MOMENCE MEADOWS REALTY LLC		365,199	316,354	18
19	V	33	PROPERTY TAXES		MOMENCE MEADOWS REALTY LLC		41,764	41,764	19
20	V	34	RENT	1,038,000	MOMENCE MEADOWS REALTY LLC			(1,038,000)	20
21	V	31	AMORTIZATION		MOMENCE MEADOWS REALTY LLC		324,540	324,540	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			$ 1,086,845			$ 833,936	$ * (252,909)	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: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

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: 1/1/2011 Ending: 12/31/2011

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	$ 6,144,160	7/25/36	5.9000	$ 365,199	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	1,700,000	12/7/12	5.5000	74,326	6
7												7
8												8
9	TOTAL Facility Related				$39,328.00		$ 8,526,000	$ 7,844,160			$ 439,525	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	$ 7,844,160			$ 439,525	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: 1/1/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 56,636	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.)		$ 42,004	2
3. Under or (over) accrual (line 2 minus line 1).		$ (14,632)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 56,396	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.		$ 41,764	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	61,732	8
	2007	62,998	9
	2008	41,265	10
	2009	41,764	11
	2010	42,004	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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

2010 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-11-19-306-007	NURSING HOME	$ 42,003.88	$ 42,003.88
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 42,003.88	$ 42,003.88

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 1/1/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,850 B. General Construction Type: Exterior BRICK Frame CONCRETE/STEEL Number of Stories 1

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] 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: 20,849
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: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140		2006		$ 2,000,000	$ 51,288	39	$ 51,282	$ (6)	$ 282,057	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse Call Light			11/30/2006	26,050	668	39	668		4,008	9
10	A/C on Roof			1/20/2007	420	11	39	11		48	10
11	A/C on Roof			2/16/2007	4,424	113	39	113		510	11
12											12
13	Nurse Call System			5/30/2007	280	7	39	7		32	13
14											14
15											15
16	Replace Locks			11/15/2007	7,700	197	39	197		888	16
17	Replace Locks			11/15/2007	104	3	39	3		12	17
18	Exhaust Vent and Filter			11/27/2007	932	24	39	24		107	18
19	Shower Remodeling			6/20/2008	3,750	96	39	96		385	19
20											20
21	New Compressor on Walk In Freezer			1/24/2008	2,158	55	39	55		221	21
22	Sidewalks			3/10/2008	4,289	110	39	110		440	22
23	Asphalt Driveway			4/9/2008	5,775	148	39	148		592	23
24	Asphalt Driveway			4/22/2008	5,775	148	39	148		592	24
25	Shower Room Tiles			4/30/2008	9,483	243	39	243		972	25
26	Drywall, Ultrasteel, Concrete, Sand, etc			5/31/2008	1,129	29	39	29		116	26
27	Mortar			6/8/2008	321	8	39	8		33	27
28	Grout and Mortar			6/20/2008	83	2	39	2		9	28
29	Drywall, Mortar and Paint			7/1/2008	523	13	39	13		54	29
30	Adhesive, Mortar, etc			7/5/2008	597	15	39	15		61	30
31	Adhesive, Mortar, etc			7/15/2008	126	3	39	3		13	31
32	Misc Supplies for Shower Remodeling			7/31/2008	61	2	39	2		6	32
33	Replace Heat Exchanger in Kitchen Roof-Top			12/11/2008	2,936	75	39	75		301	33
34	Carpet			12/29/2009	4,480	115	39	115		345	34
35	Remodeling (Nurse Station, Ceiling, Lighting, Wallpaper)			2/16/2009	108,504	2,782	39	2,782		8,348	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: 1/1/2011 Ending: 12/31/2011

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	Roof Improvements	4/5/2009	$ 3,500	$ 90	39	$ 90	$	$ 269	37
38	Roof Improvements	12/21/2009	3,500	90	39	90		269	38
39	Building & Shower Remodeling w/ Towel Rack	11/2/2010	1,714	44	39	44		88	39
40	Shower Remodeling & Wall Base Lining	11/17/2010	1,500	38	39	38		77	40
41	Fire Sprinkler	12/24/2010	1,395	36	39	36		72	41
42	Paint, Materials, and Wall Repairs	11/23/2010	7,900	203	39	203		405	42
43	Maintenance, Repairs, Replacements & Wages	11/23/2010	4,485	115	39	115		230	43
44	Materials	12/9/2010	1,482	38	39	38		76	44
45	Materials for Hot Water Valve & Labor	3/30/2010	1,814	47	39	47		93	45
46	Supplies	11/18/2010	1,536	39	39	39		79	46
47	Replace Flame Sensor/Ignitor & Labor	12/1/2010	856	22	39	22		44	47
48	Partial Billing for Cooler Replacement	12/8/2010	2,445	63	39	63		125	48
49	Repatched Walls, Resealed Gravel, Reflashed Drain	3/19/2010	1,650	42	39	42		85	49
50	New Soffit and Installed SPMB Patch	4/12/2010	950	24	39	24		49	50
51	Installed New Shingle Roof & Repaired Rotted Wood	11/22/2010	3,950	101	39	101		202	51
52	Remove Snow, Applied Patch to Roof, Patched 2 Holes	12/27/2010	750	19	39	19		38	52
53	Cabling for New TV Jacks ($55/jack)	5/24/2010	8,000	205	39	205		410	53
54									54
55	Repaired Ramp and Asphalt	11/18/2010	2,395	61	39	61		123	55
56	Repair Leaks on Main Water Supply and Dishwasher	6/8/2011	1,297	39	39	19	(20)	39	56
57	Replacement of Heat Exchanger	12/2/2010	1,384	42	39	35	(7)	42	57
58	Cooler Replacement	12/14/2010	2,445	75	39	63	(12)	75	58
59	Heavy Asphalt Coating to Roof	5/23/2011	950	29	39	16	(13)	29	59
60	Patching of roof and Replacement of Shingles	10/24/2011	3,000	91	39	19	(72)	91	60
61	Retrofit of light fixtures	4/28/2011	16,446	501	39	316	(185)	501	61
62	Stone/Steel Work and Concrete Replacement	9/1/2011	750	23	39	6	(17)	23	62
63	Stone/Steel Work and Concrete Replacement	9/6/2011	750	23	39	6	(17)	23	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,266,742	$ 58,258		$ 57,909	$ (349)	$ 303,707	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: 1/1/2011 Ending: 12/31/2011

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	$ 119,759	$ 15,888	$ 18,393	$ 2,505	various	$ 83,826	71
72	Current Year Purchases	24,744	24,743	1,999	(22,744)	various	24,744	72
73	Fully Depreciated Assets	29,889		36	36	various	29,889	73
74								74
75	TOTALS	$ 174,392	$ 40,631	$ 20,428	$ (20,203)		$ 138,459	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,541,134	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 98,889	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 78,337	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (20,552)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 442,166	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: 1/1/2011 Ending: 12/31/2011

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: 1/1/2011 Ending: 12/31/2011

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: 1/1/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$		$ 215,280	$		$ 215,280	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			35,436			35,436	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			169,582			169,582	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				218,118		218,118	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY/LAB	39-2					13,172		13,172	12
13	Other (specify):									13
14	TOTAL			$		$ 420,298	$ 231,290		$ 651,588	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

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ (107,690)	$ (962)	1
2	Cash-Patient Deposits	(4,723)	(4,723)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,313,128	4,951,482	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(17,068)	(17,068)	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)**	$ 4,183,647	$ 4,928,729	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	281,429	281,429	15
16	Equipment, at Historical Cost	104,456	163,456	16
17	Accumulated Depreciation (book methods)	(113,755)	(442,166)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	42,364	312,704	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(14,828)	(113,955)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Goodwill/Escrow**		2,839,994	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 299,666	$ 5,141,462	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,483,313	$ 10,070,191	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 303,822	$ 303,822	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	355,095	355,095	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		62,824	32
33	Accrued Interest Payable		1,243	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Working Capital Note**	1,700,000	1,700,000	36
37	**Related Party Payable**	1,924,916	1,924,916	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,283,833	$ 4,347,900	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,144,160	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,144,160	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,283,833	$ 10,492,060	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 199,480	$ (421,869)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,483,313	$ 10,070,191	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (219,472)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (219,472)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	568,954	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	(150,002)	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)**	$ 418,952	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)**	$ 199,480	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: 1/1/2011 Ending: 12/31/2011

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	$ 6,736,927	1
2	Discounts and Allowances for all Levels	(540,594)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,196,333	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	730,106	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 730,106	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	213,543	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,928	19
20	Radiology and X-Ray	1,331	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 241,802	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,674	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,674	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	767	28
28a	MISCELLANEOUS REVENUE	39,812	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 40,579	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,210,494	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	912,487	31
32	Health Care	2,958,301	32
33	General Administration	1,305,580	33
	B. Capital Expense		
34	Ownership	1,157,232	34
	C. Ancillary Expense		
35	Special Cost Centers	231,290	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)***	$ 6,641,540	40
41	**Income before Income Taxes (line 30 minus line 40)****	568,954	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 568,954	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: 1/1/2011 Ending: 12/31/2011

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,230	3,183	$ 87,455	$ 27.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,273	9,740	334,674	34.36	3
4	Licensed Practical Nurses	29,391	33,301	853,713	25.64	4
5	CNAs & Orderlies	76,132	83,552	836,311	10.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	8,035	8,925	85,176	9.54	9
10	Activity Assistants					10
11	Social Service Workers	2,562	3,137	57,214	18.24	11
12	Dietician	15,798	17,686	180,002	10.18	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,963	2,187	32,713	14.96	17
18	Housekeepers	17,199	18,713	184,561	9.86	18
19	Laundry	6,843	7,914	72,810	9.20	19
20	Administrator	2,013	2,143	87,086	40.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,662	10,961	176,405	16.09	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	1,927	2,055	28,585	13.91	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	183,028	203,497	$ 3,016,705 *	$ 14.82	34

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	8-3	35
36	Medical Director		8,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	645	32,250	16-3	38
39	Pharmacist Consultant	164	8,189	16-3	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	187	6,555	13-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,425	$ 70,394		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
T'Kira Siler	Administrator	0%	$ 31,926
Michael Wartman	Administrator	0%	55,160
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 87,086

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Bradley Associates	Accounting	$ 14,460
Johnson, Goldberg & Brown	Accounting	3,000
Infinity Healthcare Mgmt.	Management Co.	228,000
Misc. Legal	Legal	1,430
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 246,890

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,720
Unemployment Compensation Insurance	79,260
FICA Taxes	230,211
Employee Health Insurance	169,575
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	712
Pension Expense	22,693
Employee Expense	13,463
TOTAL (agree to Schedule V, line 22, col.8)	$ 604,634

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	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
NGS	600
Kankakee County	500
Illinois Secretary of State	277
State of Illinois	25
Momence Realty - Filing Fees	25
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,407

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage/Auto-Allowance	3,326
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,326

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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: 1/1/2011 Ending: 12/31/2011

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. $ **42,406** 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