



Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB# 0048033 Report Period Beginning: 1/1/07 Ending: 12/31/07

## 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 \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>140</u>	Skilled (SNF)	<u>140</u>	<u>51,100</u>	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	<u>140</u>	TOTALS	<u>140</u>	<u>51,100</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>31,923</u>	<u>1,741</u>	<u>5,856</u>	<u>39,520</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>31,923</u>	<u>1,741</u>	<u>5,856</u>	<u>39,520</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.34%

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)

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

G. Do pages 3 &amp; 4 include expenses for services or investments not directly related to patient care?

YES  NO 

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO 

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  Date 7/1/06 NO 

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 140 and days of care provided 4,623Medicare Intermediary NATIONAL GOVERNMENT SERVICES

## IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number **MOMENCE MEADOWS NURSING & REH** # **0048033** Report Period Beginning: **1/1/07** Ending: **12/31/07**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	186,044	16,921	9,711	212,676		212,676	(1,485)	211,191		1
2	Food Purchase		190,916		190,916		190,916		190,916		2
3	Housekeeping	130,915	24,046		154,961		154,961	(5)	154,956		3
4	Laundry	89,036	10,558		99,594		99,594		99,594		4
5	Heat and Other Utilities			181,040	181,040		181,040	659	181,699		5
6	Maintenance	46,948	6,899	26,784	80,631		80,631	(1,200)	79,431		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>452,943</b>	<b>249,340</b>	<b>217,535</b>	<b>919,818</b>		<b>919,818</b>	<b>(2,031)</b>	<b>917,787</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,500	8,500		8,500		8,500		9
10	Nursing and Medical Records	1,948,821	113,278	1,745	2,063,844		2,063,844	(18,369)	2,045,475		10
10a	Therapy			243,641	243,641		243,641		243,641		10a
11	Activities	81,882	30,894		112,776		112,776		112,776		11
12	Social Services	46,780	1,577	4,119	52,476		52,476		52,476		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Pharm Consult</b>			2,650	2,650		2,650		2,650		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,077,483</b>	<b>145,749</b>	<b>260,655</b>	<b>2,483,887</b>		<b>2,483,887</b>	<b>(18,369)</b>	<b>2,465,518</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	126,210			126,210		126,210		126,210		17
18	Directors Fees										18
19	Professional Services			214,745	214,745		214,745	(140,274)	74,471		19
20	Dues, Fees, Subscriptions & Promotions			2,149	2,149		2,149	250	2,399		20
21	Clerical & General Office Expenses	93,059	69,438	8,872	171,369		171,369	2,781	174,150		21
22	Employee Benefits & Payroll Taxes			506,059	506,059		506,059	12,772	518,831		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,596	12,596		12,596	7,090	19,686		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			141,998	141,998		141,998	70,143	212,141		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>219,269</b>	<b>69,438</b>	<b>886,419</b>	<b>1,175,126</b>		<b>1,175,126</b>	<b>(47,238)</b>	<b>1,127,888</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,749,695</b>	<b>464,527</b>	<b>1,364,609</b>	<b>4,578,831</b>		<b>4,578,831</b>	<b>(67,638)</b>	<b>4,511,193</b>		<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB #0048033 Report Period Beginning: 1/1/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			7,583	7,583	7,583	59,711	67,294			30
31	Amortization of Pre-Op. & Org.			1,764	1,764	1,764	367,658	369,422			31
32	Interest			165,323	165,323	165,323	784,301	949,624			32
33	Real Estate Taxes						64,334	64,334			33
34	Rent-Facility & Grounds			1,038,000	1,038,000	1,038,000	(1,038,000)				34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,212,670	1,212,670	1,212,670	238,004	1,450,674			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		130,950		130,950	130,950		130,950			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	<b>TOTAL Special Cost Centers</b>		130,950	76,650	207,600	207,600		207,600			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,749,695	595,477	2,653,929	5,999,101	5,999,101	170,366	6,169,467			45

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

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB

# 0048033

Report Period Beginning: 1/1/07

Ending: 12/31/07

**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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				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	(42)	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	(8,385)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(17,208)	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	(26,905)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (52,540)		\$	30

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

		1	2	
		Amount	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)	222,906	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 222,906		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 170,366		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS  
**MOMENCE MEADOWS NURSING & REHAB**

ID# 0048033

Report Period Beginning: 1/1/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	VENDING INCOME	\$ (1,200)	6	1
2	COMMUTING	(3,235)	24	2
3	MISCELLANEOUS REVENUE - FOOD	(1,443)	1	3
4	MISCELLANEOUS REVENUE - OFFICE	(2,157)	21	4
5	MISCELLANEOUS REVENUE - EMPLOYEE EXP	(496)	22	5
6	MISCELLANEOUS REVENUE - HOUSEKEEPING	(5)	3	6
7	MISCELLANEOUS REVENUE - NURSING	(18,369)	10	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	<b>Total</b>	(26,905)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number MOMENCE MEADOWS NURSING &amp; REHAB

# 0048033

Report Period Beginning:

1/1/07

Ending:

12/31/07

## 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)	
	<b>A. General Services</b>													
1	Dietary	(1,485)	0	0	0	0	0	0	0	0	0	0	(1,485)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(5)	0	0	0	0	0	0	0	0	0	0	(5)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	659	0	0	0	0	0	0	0	0	0	659	5
6	Maintenance	(1,200)	0	0	0	0	0	0	0	0	0	0	(1,200)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,690)</b>	<b>659</b>	<b>0</b>	<b>(2,031)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(18,369)	0	0	0	0	0	0	0	0	0	0	(18,369)	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	<b>TOTAL Health Care and Programs</b>	<b>(18,369)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(18,369)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(140,274)	0	0	0	0	0	0	0	0	0	(140,274)	19
20	Fees, Subscriptions & Promotions	0	250	0	0	0	0	0	0	0	0	0	250	20
21	Clerical & General Office Expenses	(27,750)	30,531	0	0	0	0	0	0	0	0	0	2,781	21
22	Employee Benefits & Payroll Taxes	(496)	13,268	0	0	0	0	0	0	0	0	0	12,772	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,235)	10,325	0	0	0	0	0	0	0	0	0	7,090	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	70,143	0	0	0	0	0	0	0	0	0	70,143	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(31,481)</b>	<b>(15,757)</b>	<b>0</b>	<b>(47,238)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(52,540)</b>	<b>(15,098)</b>	<b>0</b>	<b>(67,638)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/07 Ending: 12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	59,711	0	0	0	0	0	0	0	0	0	59,711	30
31	Amortization of Pre-Op. & Org.	0	367,658	0	0	0	0	0	0	0	0	0	367,658	31
32	Interest	0	0	784,301	0	0	0	0	0	0	0	0	784,301	32
33	Real Estate Taxes	0	0	64,334	0	0	0	0	0	0	0	0	64,334	33
34	Rent-Facility & Grounds	0	(1,038,000)	0	0	0	0	0	0	0	0	0	(1,038,000)	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>(610,631)</b>	<b>848,635</b>	<b>0</b>	<b>238,004</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(52,540)</b>	<b>(625,729)</b>	<b>848,635</b>	<b>0</b>	<b>170,366</b>	<b>45</b>							

**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
<a href="#">SEE ATTACHMENT #1</a>						

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.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	19	PROFESSIONAL FEES	\$ 198,000	NEW YORK BOYS MANAGEMENT	46.25%	\$	\$ (198,000)	1
2	V	5	TELEPHONE			659		659	2
3	V	19	PROFESSIONAL FEES			1,956		1,956	3
4	V	21	OFFICE EXPENSE			30,503		30,503	4
5	V	22	LIFE INSURANCE / PENSION			13,268		13,268	5
6	V	24	AUTO/TRAVEL EXPENSE			10,325		10,325	6
7	V	34	RENT	1,038,000	MOMENCE MEADOWS NEUROLOGICAL AND REHABILITATION REALTY, LLC			(1,038,000)	7
8	V	19	PROFESSIONAL FEES			55,770		55,770	8
9	V	20	FILING FEES			250		250	9
10	V	21	BANK CHARGE			28		28	10
11	V	26	PROPERTY INSURANCE			70,143		70,143	11
12	V	30	DEPRECIATION			59,711		59,711	12
13	V	31	AMORTIZATION			367,658		367,658	13
14	Total		\$ 1,236,000			\$ 610,271	\$ *	(625,729)	14

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

**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.  YES  NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	INTEREST	\$			\$ 784,301	\$ 784,301	15
16	V	33	PROPERTY TAXES				64,334	64,334	16
17	V								17
18	V								18
19	V								19
20	V								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			\$			\$ 848,635	\$ * 848,635	39

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

**ATTACHMENT #1**

OWNERS

NAME	OWNERSHIP %
MICHAEL BLISKO	30.000%
MOISHE GUBIN	32.000%
STEVEN BLISKO	5.000%
BERNARD STEINBURG	3.000%
A&F GENERAL PARTNERSHIP	<u>30.000%</u>
	<u>100.000%</u>

OTHER RELATED BUSINESS ENTITIES

NAME	CITY	TYPE OF BUSINESS
NEW YORK BOYS MANAGEMENT	CROWN POINT, IN	MANAGEMENT CO.

NOTE: NEW YORK BOYS MANAGEMENT IS OWNED BY MOISHE GUBIN AND MICHAEL BLISKO.

Facility Name & ID Number MOMENCE MEADOWS NURSING & RE] # 0048033 Report Period Beginning: 1/1/07 Ending: 12/31/07

## 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	STEVEN BLISKO	ADMINISTRATOR	ADMIN	5.00		40	100.00	SALARY	\$ 56,333	17-1	1
2								MILEAGE	2,000	24-3	2
3	MICHAEL BLISKO			30.00							3
4	MOISHE GUBIN			32.00							4
5	A&F GENERAL PARTNERSHIP			30.00							5
6	BERNARD STEINBURG			3.00							6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 58,333		13

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

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

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB # 0048033 Report Period Beginning: 1/1/07 Ending: 12/31/07

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number MOMENCE MEADOWS NURSING & REH # 0048033 Report Period Beginning: 1/1/07 Ending: 12/31/07

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	CAMBRIDGE RALTY		X	HUD MORTGAGE	\$39,328.00	7/25/01	\$ 6,526,000	\$ 6,526,000	7/25/36	5.9000	\$ 767,856	1								
2	JACOB BRAFF		X	MORTGAGE	\$10,807.00	7/1/06	350,000	203,227	7/1/09	7.0000	16,445	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	MIDWEST BANK & TRUST CO.		X	WORKING CAPITAL	NONE	7/11/06	2,000,000	2,010,000		8.2500	165,323	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$50,135.00		\$ 8,876,000	\$ 8,739,227			\$ 949,624	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 8,876,000	\$ 8,739,227			\$ 949,624	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.)

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 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 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-11-19-306-007</u>	<u>NURSING HOME</u>	\$ <u>61,731.56</u>	\$ <u>61,731.56</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>61,731.56</u>	\$ <u>61,731.56</u>

**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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

1/1/07

Ending:

12/31/07

**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  (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  (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).

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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: 296,796 2. Number of Years Over Which it is Being Amortized: 15  
3. Current Period Amortization: 20,022 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>		<u>7/1/2006</u>	<u>\$ 100,000</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 100,000</b>	3

**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	\$	\$ 76,923	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9		Nurse Call Light		11/30/2006	26,050	668	39	668		1,336	9
10		A/C on Roof		1/20/2007	420	10	39	10		10	10
11		A/C on Roof		2/16/2007	4,424	95	39	95		95	11
12		Refrigerator		4/27/2007	537	9	39	9		9	12
13		Nurse Call System		5/30/2007	280	4	39	4		4	13
14		laundry		9/11/2007	1,967	17	39	17		17	14
15		Freezer		9/20/2007	1,432	9	39	9		9	15
16		Replace Locks		11/15/2007	7,700	33	39	33		33	16
17		Replace Locks		11/15/2007	104	0	39	0		0	17
18		Exhaust Vent and Filter		11/27/2007	932	2	39	2		2	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

\*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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								49
50								50
51								51
52								52
53								53
54								54
55								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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70

\*\*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: 1/1/07 Ending: 12/31/07

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	\$ 88,389	\$ 14,307	\$ 14,307	\$	Various	\$ 20,185	71
72	Current Year Purchases	8,229	858	858		Various	858	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 96,618	\$ 15,165	\$ 15,165	\$		\$ 21,043	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	N/A			\$	\$	\$	\$		\$	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)	\$ 2,240,464	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,294	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 67,294	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 99,481	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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	10a-3	hrs	\$		\$ 105,522	\$		\$ 105,522	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			22,583			22,583	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			115,536			115,536	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				117,476		117,476	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>Radiology &amp; Lab</b>	39-2					13,474		13,474	13
14	<b>TOTAL</b>			\$		\$ 243,641	\$ 130,950		\$ 374,591	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MOMENCE MEADOWS NURSING & REHAB# 0048033Report Period Beginning: 1/1/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 273,040	\$ 324,493	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,733,030	1,733,030	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	112,932	112,932	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,119,002	\$ 2,170,455	10
	<b>B. Long-Term Assets</b>			
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	43,846	43,846	15
16	Equipment, at Historical Cost	37,617	96,617	16
17	Accumulated Depreciation (book methods)	(14,129)	(103,695)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,456	296,795	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,528)	(30,562)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <b>Goodwill &amp; Escrow</b>		5,117,138	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 90,262	\$ 7,520,139	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,209,264	\$ 9,690,594	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 299,198	\$ 1,345,403	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	220,441	220,441	30
31	Accrued Taxes Payable (excluding real estate taxes)	(241)	(241)	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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 519,398	\$ 1,565,603	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,010,000	8,739,227	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,010,000	\$ 8,739,227	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,529,398	\$ 10,304,830	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (320,134)	\$ (614,236)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,209,264	\$ 9,690,594	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (53,392)	1
2	Restatements (describe):		2
3	Distributions to Owners	(50,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (103,392)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(81,740)	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	(135,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <b>Rounding</b>	(2)	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (216,742)</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (320,134)</b>	24 *

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

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**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,559,265	1
2	Discounts and Allowances for all Levels	(336,659)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,222,606	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	511,152	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 511,152	8
<b>C. Other Operating Revenue</b>			
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	133,596	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,401	19
20	Radiology and X-Ray	1,450	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 157,447	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Vending Income</b>	1,200	28
28a	<b>Miscellaneous</b>	24,957	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 26,157	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,917,361	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	919,818	31
32	Health Care	2,483,887	32
33	General Administration	1,175,126	33
<b>B. Capital Expense</b>			
34	Ownership	1,212,670	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	130,950	35
36	Provider Participation Fee	76,650	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,999,101	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(81,740)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (81,740)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number **MOMENCE MEADOWS NURSING & REHAB**

# **0048033**

Report Period Beginning:

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,360	1,459	\$ 55,502	\$ 38.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,239	9,461	233,103	24.64	3
4	Licensed Practical Nurses	31,218	37,980	804,459	21.18	4
5	CNAs & Orderlies	82,437	85,991	831,470	9.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,729	8,256	81,882	9.92	9
10	Activity Assistants					10
11	Social Service Workers	3,453	3,653	46,780	12.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,859	21,487	186,044	8.66	15
16	Dishwashers					16
17	Maintenance Workers	3,207	3,368	46,948	13.94	17
18	Housekeepers	14,145	15,196	130,915	8.62	18
19	Laundry	10,699	11,670	89,036	7.63	19
20	Administrator	3,832	4,122	126,210	30.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,820	7,974	93,059	11.67	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	1,507	1,926	24,287	12.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>194,505</b>	<b>212,543</b>	<b>\$ 2,749,695 *</b>	<b>\$ 12.94</b>	<b>34</b>

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	277	\$ 9,711	10-3	35
36	Medical Director				36
37	Medical Records Consultant	50	1,745	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	53	2,650	10-3	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	118	4,119	12-3	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>498</b>	<b>\$ 18,225</b>		<b>49</b>

**C. CONTRACT NURSES**

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





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# 0048033

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**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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,190 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. N/A
- (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.
- (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? NA Indicate the amount. \$ NA
- (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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

# Legal Invoices