

		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

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.

<p>I. IDPH Facility ID Number: <u>0036848</u></p> <p>Facility Name: <u>GOLDEN MOMENTS SENIOR CARE CENTER</u></p> <p>Address: <u>1021 NORTH CHURCH STREET</u> <u>JACKSONVILLE</u> <u>62650</u> Number City Zip Code</p> <p>County: <u>MORGAN</u></p> <p>Telephone Number: <u>(217) 245-4174</u> Fax # <u>(217) 243-5901</u></p> <p>IDPA ID Number: <u>36-1274300</u></p> <p>Date of Initial License for Current Owners: <u>01/31/91</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MELVIN SIEGEL</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>MELVIN SIEGEL</u>			(Title) <u>PRESIDENT</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>		(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																								
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																								
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																								
	<input checked="" type="checkbox"/> "Sub-S" Corp.																																									
	<input type="checkbox"/> Limited Liability Co.																																									
	<input type="checkbox"/> Trust																																									
	<input type="checkbox"/> Other _____																																									
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																								
	(Type or Print Name) <u>MELVIN SIEGEL</u>																																									
	(Title) <u>PRESIDENT</u>																																									
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____																																								
	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>																																									
	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>																																									
	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																																									

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER

0036848 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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	113	Skilled (SNF)	113	41,245	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	113	TOTALS	113	41,245	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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			1,387	1,387	8
9	SNF/PED					9
10	ICF	20,908	1,450		22,358	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,908	1,450	1,387	23,745	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.57%

D. How many bed-hold days during this year were paid by Public Aid? _____ (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

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 1/31/91

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1/31/91 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 23 and days of care provided 1,387

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

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

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CEN # 0036848 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	97,970	6,289	6,644	110,903		110,903		110,903		1
2	Food Purchase		107,411		107,411		107,411	(866)	106,545		2
3	Housekeeping	49,938	10,275		60,213		60,213		60,213		3
4	Laundry	35,869	4,973		40,842		40,842		40,842		4
5	Heat and Other Utilities			65,371	65,371		65,371	1,597	66,968		5
6	Maintenance	28,026	10,761	16,381	55,168		55,168	(4,382)	50,786		6
7	Other (specify):*			4,845	4,845		4,845	84	4,929		7
8	TOTAL General Services	211,803	139,709	93,241	444,753		444,753	(3,567)	441,186		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	854,380	35,531	11,208	901,119		901,119	9,617	910,736		10
10a	Therapy			1,473	1,473		1,473		1,473		10a
11	Activities	20,402	1,915	3,335	25,652		25,652	(3,335)	22,317		11
12	Social Services	35,744			35,744		35,744		35,744		12
13	Nurse Aide Training			352	352		352		352		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	910,526	37,446	22,368	970,340		970,340	6,282	976,622		16
	C. General Administration										
17	Administrative	60,173		16,342	76,515		76,515	6,779	83,294		17
18	Directors Fees										18
19	Professional Services			131,445	131,445		131,445	(90,443)	41,002		19
20	Dues, Fees, Subscriptions & Promotions			26,799	26,799		26,799	(16,398)	10,401		20
21	Clerical & General Office Expenses	66,719	11,792	75,946	154,457		154,457	(19,796)	134,661		21
22	Employee Benefits & Payroll Taxes			209,153	209,153		209,153		209,153		22
23	Inservice Training & Education			2,255	2,255		2,255	294	2,549		23
24	Travel and Seminar			949	949		949	7,744	8,693		24
25	Other Admin. Staff Transportation			2,724	2,724		2,724	4,396	7,120		25
26	Insurance-Prop.Liab.Malpractice			104,000	104,000		104,000	532	104,532		26
27	Other (specify):*			34,414	34,414		34,414	(22,651)	11,763		27
28	TOTAL General Administration	126,892	11,792	604,027	742,711		742,711	(129,543)	613,168		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,249,221	188,947	719,636	2,157,804		2,157,804	(126,828)	2,030,976		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	6,644
	REPAIRS & MAINTENANCE	0
		0
		6,644
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	10,986
	ELECTRICITY	35,704
	WATER	13,655
	CABLE TV - LOBBY	5,026
		0
		65,371
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,155
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE CONSULTANT	12,978
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	1,248
		0
		0
		0
		16,381
7	OTHER	
	SCAVENGER	4,260
	SECURITY SERVICE	585
		4,845
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	1,268
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	8,505
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	400
	PHARMACY CONSULTANT XVIII B 39-2	660
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	375
		0
		0
		11,208
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	821
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	652
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		1,473
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,335
		0
		3,335
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	352
		352

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	16,342
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	10,398
	ADMINISTRATIVE CONSULTANTS XIX C	46,998
	PROFESSIONAL FEES XIX C	28,870
	BOOKKEEPING/ADMINIST. SERVICE	45,179
20	FEES,SUBSCRIPTIONS,PROMOTIONS	131,445
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,844
	EMPLOYEE WANT ADS XIX F	2,321
	CONTRIBUTIONS VI 20 XIX F	230
	DUES & SUBSCRIPTIONS XIX F	5,058
	LICENSES & PERMITS XIX F	2,230
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	734
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	382
21	CLERICAL & GENERAL OFFICE EXPENSES	26,799
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	714
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	55,536
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	18,239
	MESSENGER SERVICE	1,457
		0
		75,946

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	99,631
	UNEMPLOYMENT COMPENSATION XIX D	17,639
	WORKERS COMPENSATION INSURANCI XIX D	44,000
	HOSPITALIZATION INSURANCE XIX D	42,397
	EMPLOYEE BENEFITS - OTHER XIX D	5,486
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		209,153
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	2,255
		2,255
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	949
		0
		0
		949
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	2,724
		2,724
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	104,000
		104,000
27	OTHER	
	BAD DEBTS VI 24	34,414
		0
		34,414

GRAND TOTAL COLUMN 3 OTHER

719,636

Facility Name & ID Number

GOLDEN MOMENTS SENIOR CARE CENTER

#0036848

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			17,358	17,358		17,358	29,175	46,533			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,088	17,088		17,088	96,338	113,426			32
33	Real Estate Taxes			27,812	27,812		27,812		27,812			33
34	Rent-Facility & Grounds			105,027	105,027		105,027	(99,120)	5,907			34
35	Rent-Equipment & Vehicles			22,170	22,170		22,170	5,996	28,166			35
36	Other (specify):*											36
37	TOTAL Ownership			189,455	189,455		189,455	32,389	221,844			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		14,802	54,532	69,334		69,334		69,334			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,867	61,867		61,867		61,867			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		14,802	116,399	131,201		131,201		131,201			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,249,221	203,749	1,025,490	2,478,460		2,478,460	(94,439)	2,384,021			45

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

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	OHF 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	3,859	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	(866)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(55,536)	21		18
19	Entertainment		20		19
20	Contributions	(964)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,414)	27		24
25	Fund Raising, Advertising and Promotional	(15,844)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	(12,520)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (116,285)		\$	30

OHF 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	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)	21,846		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 21,846		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (94,439)		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.		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

GOLDEN MOMENTS SENIOR CARE CENTER

ID# 0036848

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING	\$ (12,520)	21	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				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	(12,520)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER# 0036848

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(866)	0	0	0	0	0	0	0	0	0	0	(866)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,597	0	0	0	0	0	0	0	0	0	1,597	5
6	Maintenance	0	(4,382)	0	0	0	0	0	0	0	0	0	(4,382)	6
7	Other (specify):*	0	84	0	0	0	0	0	0	0	0	0	84	7
8	TOTAL General Services	(866)	(2,701)	0	0	0	0	0	0	0	0	0	(3,567)	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	0	9,617	0	0	0	0	0	0	0	0	0	9,617	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,335)	0	0	0	0	0	0	0	0	0	(3,335)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	0	6,282	0	0	0	0	0	0	0	0	0	6,282	16
	C. General Administration													
17	Administrative	0	6,779	0	0	0	0	0	0	0	0	0	6,779	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(90,443)	0	0	0	0	0	0	0	0	0	(90,443)	19
20	Fees, Subscriptions & Promotions	(16,808)	410	0	0	0	0	0	0	0	0	0	(16,398)	20
21	Clerical & General Office Expenses	(68,056)	0	48,260	0	0	0	0	0	0	0	0	(19,796)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	294	0	0	0	0	0	0	0	0	294	23
24	Travel and Seminar	0	0	7,744	0	0	0	0	0	0	0	0	7,744	24
25	Other Admin. Staff Transportation	0	0	4,396	0	0	0	0	0	0	0	0	4,396	25
26	Insurance-Prop.Liab.Malpractice	0	0	532	0	0	0	0	0	0	0	0	532	26
27	Other (specify):*	(34,414)	0	11,763	0	0	0	0	0	0	0	0	(22,651)	27
28	TOTAL General Administration	(119,278)	(83,254)	72,989	0	(129,543)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(120,144)	(79,673)	72,989	0	(126,828)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER# 0036848

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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	3,859	0	384	24,932	0	0	0	0	0	0	0	29,175	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	101	96,237	0	0	0	0	0	0	0	96,338	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	5,907	(105,027)	0	0	0	0	0	0	0	(99,120)	34
35	Rent-Equipment & Vehicles	0	0	5,996	0	0	0	0	0	0	0	0	5,996	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	3,859	0	12,388	16,142	0	32,389	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)	(116,285)	(79,673)	85,377	16,142	0	(94,439)	45						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	CONSULTING,
		LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES		BOOKKEEPING
		RIVER VIEW MANOR	LOVES PARK			
		PARKVIEW TERRACE	EAST MOLINE	SKYVIEW NURSING	SKOKIE, IL	REAL ESTATE
		SPRINGFIELD TERRACE	SPRINGFIELD	ASSOCIATES LTD		
		VANDALIA TERRACE	VANDALIA			

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)	
1	V	6 MAINTENANCE CONSULTANT	\$ 12,978			\$	\$ (12,978)	1
2	V	10 PSYCHO-SOCIAL CONSULTANT	3,225				(3,225)	2
3	V	11 ACTIVITIES CONSULTANT	3,335				(3,335)	3
4	V	19 ADMIN. /BKBP. FEES	45,179				(45,179)	4
5	V	19 ADMIN. /CONSULT. FEES	46,998				(46,998)	5
6	V							6
7	V	5 ELECTRICITY/GAS				1,597	1,597	7
8	V	6 MAINTENANCE				8,596	8,596	8
9	V	7 SCAVENGER				84	84	9
10	V	10 PSYCH-SOCIAL & NURSING CONSULT				12,842	12,842	10
11	V	17 ADMINISTRATIVE SALARIES				6,779	6,779	11
12	V	19 PROFESSIONAL FEES				1,734	1,734	12
13	V	20 ADVERTISING				410	410	13
14	Total		\$ 111,715			\$ 32,042	\$ * (79,673)	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	21 TOTAL OFFICE	\$	MELVIN ENTERPRISES, LTD.		\$ 48,260	\$ 48,260	15
16	V	23 SEMINARS				294	294	16
17	V	24 TRAVEL				7,744	7,744	17
18	V	25 TRANSPORTATION				4,396	4,396	18
19	V	27 EMPLOYEE BENEFITS				11,763	11,763	19
20	V	30 DEPRECIATION (SL)				384	384	20
21	V	32 INTEREST				101	101	21
22	V	34 OFFICE RENT				5,907	5,907	22
23	V	35 EQUIPMENT RENT				5,996	5,996	23
24	V	26 INSURANCE				532	532	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		\$			\$ 85,377	\$ * 85,377	39

* 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	34 RENT	\$ 105,027	SKYVIEW NURSING ASSOCIATES		\$	(105,027)	15
16	V	30 DEPRECIATION				24,932	24,932	16
17	V	32 INTEREST				96,237	96,237	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		\$ 105,027			\$ 121,169	\$ * 16,142	39

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

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization MAVIN ENTERPRISES, LTD.
 Street Address 3845 OAKTON
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-0100
 Fax Number (847) 679-0647

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	5	ELECTRICITY/GAS	PATIENT DAYS	141,473	7	\$ 9,514	\$ 23,745	\$ 1,597	1
2	6	MAINTENANCE	PATIENT DAYS	141,473	7	51,216	50,100	23,745	8,596
3	7	SCAVENGER	PATIENT DAYS	141,473	7	500	23,745	84	3
4	10	PSYCH-SOCIAL & NURSING	PATIENT DAYS	141,473	7	76,511	23,745	12,842	4
5	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	141,473	7	40,388	40,388	23,745	6,779
6	19	PROFESSIONAL FEES	PATIENT DAYS	141,473	7	10,333	23,745	1,734	6
7	20	ADVERTISING	PATIENT DAYS	141,473	7	2,442	23,745	410	7
8	21	TOTAL OFFICE	PATIENT DAYS	141,473	7	287,536	218,675	23,745	48,260
9	23	SEMINARS	PATIENT DAYS	141,473	7	1,750	23,745	294	9
10	24	TRAVEL	PATIENT DAYS	141,473	7	46,140	23,745	7,744	10
11	25	TRANSPORTATION	PATIENT DAYS	141,473	7	26,191	23,745	4,396	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	141,473	7	70,083	23,745	11,763	12
13	30	DEPRECIATION (SL)	PATIENT DAYS	141,473	7	2,285	23,745	384	13
14	32	INTEREST	PATIENT DAYS	141,473	7	601	23,745	101	14
15	34	OFFICE RENT	PATIENT DAYS	141,473	7	35,195	23,745	5,907	15
16	35	EQUIPMENT RENT	PATIENT DAYS	141,473	7	35,725	23,745	5,996	16
17	26	INSURANCE	PATIENT DAYS	141,473	7	3,172	23,745	532	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 699,582	\$ 309,163	\$ 117,419	25

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	RELATED PARTY						\$	\$			\$	1						
2	SKYVIEW NURSING ASSOCIATES											2						
3	BANK FINANCIAL		X	MORTGAGE		2/97	1,090,000	1,022,946		5.2500	96,237	3						
4												4						
5												5						
Working Capital																		
6	BANK FINANCIAL		X	LINE OF CREDIT	DEMAND	6/29/99	150,000			5.2500	16,897	6						
7											191	7						
8												8						
9	TOTAL Facility Related						\$ 1,240,000	\$ 1,022,946			\$ 113,325	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 1,240,000	\$ 1,022,946			\$ 113,325	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2002 report.	\$	27,413	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.)	\$	27,475	2
3. Under or (over) accrual (line 2 minus line 1).	\$	62	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	27,750	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.	\$	27,812	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	30,393	8
	1999	26,453	9
	2000	26,667	10
	2001	27,414	11
	2002	27,475	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 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 Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GOLDEN MOMENTS SENIOR CARE CENTER COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0036848

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(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>09-17-204-013</u>	<u>NURSING HOME</u>	\$ <u>27,475.10</u>	\$ <u>27,475.10</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>27,475.10</u>	\$ <u>27,475.10</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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER

0036848

Report Period Beginning:

01/01/2003 Ending:

12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,500 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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, nurse aide 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: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>		<u>1991</u>	<u>\$ 43,632</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 43,632	3

Facility Name & ID Number **GOLDEN MOMENTS SENIOR CARE CENTER**# **0036848**

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	113	1991		\$ 785,372	\$ 24,932	31.5	\$ 24,932	\$	\$ 297,316	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	VARIOUS		1993	1,792	46	20	90	44	915	9
10	VARIOUS		1994	1,801	46	20	90	44	900	10
11	GENERATOR REPAIRS		1996	2,508	95	20	125	30	948	11
12	VENT REPAIRS		1996	1,200	30	20	60	30	425	12
13	ROOF REPAIRS		1997	50,700	1,300	20	2,535	1,235	16,689	13
14	PAINT & WALLPAPER		1997	21,655	555	20	1,082	527	6,943	14
15	REPLACEMENT SWITCH IN GENERATOR		1998	1,037	27	20	51	24	281	15
16	WALLPAPER, HARDWARE FOR WALLS		1998	5,613	144	20	280	136	1,540	16
17	HANDRAILS		1998	2,579	66	20	128	62	705	17
18	FLOOR & COVE BASE		1998	12,944	332	20	647	315	3,559	18
19	PAINTING /CARPETING		1998	9,995	256	20	499	243	2,745	19
20	ROOM SIGNS		1998	1,095	28	20	54	26	297	20
21	WALLPAPER		1999	5,374	138	20	268	130	1,340	21
22	HAND RAIL BUMPER, CAP		1999	5,034	129	20	251	122	1,255	22
23	SOFFIT INSULATION		1999	4,638	119	20	231	112	1,155	23
24	VCT INSTALLATION, FLOOR PATCH, TILE		1999	13,515	347	20	675	328	3,375	24
25	ROOM SIGNS, FRAMED ARTWORK		1999	3,685	94	20	184	90	920	25
26	HEATERS AND AIR CONDITIONING UNITS		2000	4,032	147	27.5	147		514	26
27	BUILT IN CABINETS FOR ADM. AND BOOKKEEPING OFFICE		2000	6,500	236	27.5	236		826	27
28	VCT INSTALLATION, COVE BASES, TILES, VINYL SHEET		2000	13,488	490	27.5	490		1,715	28
29	GUARD RAILS		2001	788	29	27.5	29		72	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.

See Page 12A, Line 70 for total

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

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	TOTAL (lines 4 thru 69)		\$ 955,345	\$ 29,586		\$ 33,084	\$ 3,498	\$ 344,435	70

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

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	\$ 154,542	\$ 12,704	\$ 13,065	\$ 361	5-10	\$ 112,390	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	<u>MGMT CO ALLOCATION</u>		384	384				74
75	TOTALS	\$ 154,542	\$ 13,088	\$ 13,449	\$ 361		\$ 112,390	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	<u>FACILITY</u>	<u>1988 CHEVROLET</u>	<u>1993</u>	\$ 9,422	\$	\$	\$		\$ 9,422	76
77	<u>FACILITY</u>	<u>1991 PLYMOUTH VOYAGER</u>	<u>1994</u>	8,520					8,520	77
78										78
79										79
80	TOTALS			\$ 17,942	\$	\$	\$		\$ 17,942	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)	\$ 1,171,461	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,674	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,533	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,859	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 474,767	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	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: _____ *

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: \$ 8,425 Description: SEE SCHEDULE ATTACHED

(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	FACILITY	2002 FORD VAN	\$ 762.00	\$ 9,349	17
18	FACILITY	2001 BLAZER	400.00	4,396	18
19					19
20					20
21	TOTAL		\$ #####	\$ 13,745	21

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. _____ /2004 \$ _____

13. _____ /2005 \$ _____

14. _____ /2006 \$ _____

* 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 NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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 AIDE _____</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 AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 352	\$	\$ 352
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 352	\$	\$ 352
10	SUM OF line 9, col. 1 and 2 (e)	\$	352		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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	39-3	hrs	\$		\$ 33,379	\$		\$ 33,379	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			5,224			5,224	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			15,929			15,929	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				10,231		10,231	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): FEEDING	39-2 39-2					440 4,131		440 4,131	13
14	TOTAL			\$		\$ 54,532	\$ 14,802		\$ 69,334	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER

0036848

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (64,887)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	444,120		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	780,147		8
9	Other(specify): <u>Real Estate Tax Escrow</u>	17,281		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,176,661	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	181,604		15
16	Equipment, at Historical Cost	139,890		16
17	Accumulated Depreciation (book methods)	(123,268)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 198,226	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,374,887	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 376,210	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	54,871		28
29	Short-Term Notes Payable	1,275,089		29
30	Accrued Salaries Payable	35,158		30
31	Accrued Taxes Payable (excluding real estate taxes)	49,284		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,750		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,818,362	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,818,362	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (443,475)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,374,887	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 12,047	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	22,870	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 34,917	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(478,392)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (478,392)	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)	\$ (443,475)	24 *

* This must agree with page 17, line 47.

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,970,340	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,970,340	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	27,827	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 27,827	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,901	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,901	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,000,068	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	444,753	31
32	Health Care	970,340	32
33	General Administration	742,711	33
B. Capital Expense			
34	Ownership	189,455	34
C. Ancillary Expense			
35	Special Cost Centers	69,334	35
36	Provider Participation Fee	61,867	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,478,460	40
41	Income before Income Taxes (line 30 minus line 40)**	(478,392)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (478,392)	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 GOLDEN MOMENTS SENIOR CARE CENTER

0036848

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,024	2,168	\$ 55,946	\$ 25.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,391	3,669	70,382	19.18	3
4	Licensed Practical Nurses	16,062	17,030	273,011	16.03	4
5	Nurse Aides & Orderlies	40,402	42,548	400,016	9.40	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,857	2,965	20,402	6.88	10
11	Social Service Workers	3,603	3,691	35,744	9.68	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,344	12,946	97,970	7.57	15
16	Dishwashers					16
17	Maintenance Workers	2,068	2,473	28,026	11.33	17
18	Housekeepers	7,637	8,204	49,938	6.09	18
19	Laundry	4,191	4,844	35,869	7.40	19
20	Administrator	1,941	2,086	60,173	28.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,828	4,114	54,199	13.17	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	3,785	4,008	67,545	16.85	33
34	TOTAL (lines 1 - 33)	104,133	110,746	\$ 1,249,221 *	\$ 11.28	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 6,644	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	400	10-3	37
38	Nurse Consultant	T	375	10-3	38
39	Pharmacist Consultant	H	660	10-3	39
40	Physical Therapy Consultant	L	652	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,335	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	<u>PSYCHO-SOCIAL CONSULTANT</u>				47
48					48
49	TOTAL (lines 35 - 48)		\$ 18,066		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides		N/A	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
KELLY MATHIS	ADMIN	0	\$ 60,173	Workers' Compensation Insurance	\$ 44,000	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	17,639	Advertising: Employee Recruitment	2,321	
				FICA Taxes	99,631	Health Care Worker Background Check	382	
				Employee Health Insurance	42,397	(Indicate # of checks performed <u>28</u>)		
				Employee Meals	#REF!	MARKETING/ADV/PROMO	15,844	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	964	
				EMPLOYEE BENEFITS - OTHER	5,486	LICENSES & PERMITS	2,230	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	5,058	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	410	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(964)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(15,844)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 60,173	TOTAL (agree to Schedule V, line 22, col.8)	\$ #REF!	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,401	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
FAMILY PARTNERS MANAGEMENT MANAGEMENT FEES			\$ 13,342			\$	Out-of-State Travel	\$
MELVIN SIEGEL			3,000					
							In-State Travel	949
							MGMT CO ALLOCATION	7,744
							Seminar Expense	0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 16,342	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 8,693
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			131,445					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 131,445					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER# 0036848Report Period Beginning: 01/01/2003Ending: 12/31/2003**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$4869
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (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? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ 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. _____
- (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 of Public Aid during this cost report period. \$ 61,867
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 of Public Aid, 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. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, 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