

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER

0036848 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			1,377	1,377	8
9	SNF/PED					9
10	ICF	14,212	1,423		15,635	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,212	1,423	1,377	17,012	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 41.25%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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 01/31/91

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/31/91 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 1,377

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **GOLDEN MOMENTS SENIOR CARE CEN** # **0036848** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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	81,153	4,544	4,407	90,104		90,104	0	90,104		1
2	Food Purchase		79,313		79,313	0	79,313	(86)	79,227		2
3	Housekeeping	41,667	4,224	0	45,891		45,891	0	45,891		3
4	Laundry	15,440	5,496	0	20,936	0	20,936	0	20,936		4
5	Heat and Other Utilities			56,103	56,103		56,103	1,242	57,345		5
6	Maintenance	19,384		33,112	52,496		52,496	(3,457)	49,039		6
7	Other (specify):*			3,674	3,674		3,674	60	3,734		7
8	TOTAL General Services	157,644	93,577	97,296	348,517	0	348,517	(2,241)	346,276		8
	B. Health Care and Programs										
9	Medical Director	0		11,500	11,500		11,500	0	11,500		9
10	Nursing and Medical Records	633,490	16,695	10,599	660,784		660,784	6,631	667,415		10
10a	Therapy	0		3,467	3,467		3,467	0	3,467		10a
11	Activities	21,701	1,163	10,236	33,100		33,100	(3,720)	29,380		11
12	Social Services	23,210		0	23,210		23,210	0	23,210		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	678,401	17,858	35,802	732,061	0	732,061	2,911	734,972		16
	C. General Administration										
17	Administrative	59,983		3,000	62,983		62,983	4,302	67,285		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			132,483	132,483		132,483	(85,821)	46,662		19
20	Dues, Fees, Subscriptions & Promotions			13,930	13,930		13,930	(3,541)	10,389		20
21	Clerical & General Office Expenses	24,598	4,421	27,045	56,064		56,064	19,992	76,056		21
22	Employee Benefits & Payroll Taxes			163,655	163,655	0	163,655	0	163,655		22
23	Inservice Training & Education			0	0		0	177	177		23
24	Travel and Seminar			915	915		915	8,218	9,133		24
25	Other Admin. Staff Transportation			4,152	4,152		4,152	3,793	7,945		25
26	Insurance-Prop.Liab.Malpractice			10,156	10,156		10,156	161	10,317		26
27	Other (specify):*			21,356	21,356		21,356	(7,516)	13,840		27
28	TOTAL General Administration	84,581	4,421	376,692	465,694	0	465,694	(60,235)	405,459		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	920,626	115,856	509,790	1,546,272	0	1,546,272	(59,565)	1,486,707		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	4,407
	REPAIRS & MAINTENANCE	0
		0
		4,407
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	10,689
	ELECTRICITY	30,652
	WATER	14,762
	CABLE TV - LOBBY	
		0
		56,103
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,235
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	15,687
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,830
	FIRE SERVICE	1,824
	MAINTENANCE CONSULTANT	10,536
		0
		0
		0
		33,112
7	OTHER	
	SCAVENGER	3,127
	SECURITY SERVICE	547
		0
		0
		3,674
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	11,500
		11,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	1,095
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	6,720
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	251
	PHARMACY CONSULTANT XVIII B 39-2	600
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	GERIATRIC CONSULTANT	1,073
	DENTAL	860
		10,599
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	952
	SPEECH THERAPY SERVICES	57
	OCCUPATIONAL THERAPY SERVICES	193
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	1,921
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	344
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		3,467
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	6,516
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,720
		0
		10,236
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

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	3,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	10,151
	ADMINISTRATIVE CONSULTANTS XIX C	7,416
	PROFESSIONAL FEES XIX C	34,350
	BOOKKEEPING/ADMINIST. SERVICE	80,566
20	FEES,SUBSCRIPTIONS,PROMOTIONS	132,483
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,220
	EMPLOYEE WANT ADS XIX F	2,616
	CONTRIBUTIONS VI 20 XIX F	380
	DUES & SUBSCRIPTIONS XIX F	6,814
	LICENSES & PERMITS XIX F	100
	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	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	270
	PATIENT BACKGROUND CHECKS XIX F	530
		13,930
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	913
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	15,895
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	10,194
	MESSENGER SERVICE	43
		0
		27,045

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	73,993
	UNEMPLOYMENT COMPENSATION XIX D	23,365
	WORKERS COMPENSATION INSURANC XIX D	49,360
	HOSPITALIZATION INSURANCE XIX D	14,043
	EMPLOYEE BENEFITS - OTHER XIX D	2,894
	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
		0
		163,655
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	740
	TRAVEL XIX G	175
		915
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,152
		4,152
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	10,156
		10,156
27	OTHER	
	BAD DEBTS VI 24	21,356
		21,356

GRAND TOTAL COLUMN 3 OTHER

509,790

GOLDEN MOMENTS SENIOR CARE CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	79,313	PATIENT MEALS	51036
LESS SALES TAX	(86)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	79,227	TOTAL MEALS/YEAR	51036
TOTAL PATIENT CENSUS	17,012	NET FOOD	79227
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	51036

TOTAL PATIENT MEALS	51036	COST PER MEAL	1.55
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

GOLDEN MOMENTS SENIOR CARE CENTER

#0036848

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			10,129	10,129		10,129	33,204	43,333			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			15,831	15,831		15,831	70,821	86,652			32
33	Real Estate Taxes			29,621	29,621		29,621	0	29,621			33
34	Rent-Facility & Grounds			77,445	77,445		77,445	(68,382)	9,063			34
35	Rent-Equipment & Vehicles			23,071	23,071		23,071	2,433	25,504			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			156,097	156,097	0	156,097	38,076	194,173			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		53,262	80,973	134,235		134,235	0	134,235			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			61,868	61,868		61,868	0	61,868			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	53,262	142,841	196,103	0	196,103	0	196,103			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	920,626	169,118	808,728	1,898,472	0	1,898,472	(21,489)	1,876,983			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 **GOLDEN MOMENTS SENIOR CARE CENTER**

0036848

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	7,971	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	(86)	2		13
14	Non-Care Related Interest	(2)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(15,895)	21		18
19	Entertainment	0	20		19
20	Contributions	(380)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,356)	27		24
25	Fund Raising, Advertising and Promotional	(3,220)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(964)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,932)		\$ 0	30

BHF USE ONLY					
48	49	50	51	52	

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

		1	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)	12,443		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 12,443		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (21,489)		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: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6 1
2	MARKETING SALARY	(964)	21 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	(964)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(86)	0	0	0	0	0	0	0	0	0	0	(86)	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	1,242	0	0	0	0	0	0	0	0	0	1,242	5
6	Maintenance	0	(3,457)	0	0	0	0	0	0	0	0	0	(3,457)	6
7	Other (specify):*	0	60	0	0	0	0	0	0	0	0	0	60	7
8	TOTAL General Services	(86)	(2,155)	0	0	0	0	0	0	0	0	0	(2,241)	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	6,631	0	0	0	0	0	0	0	0	0	6,631	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	(3,720)	0	0	0	0	0	0	0	0	0	(3,720)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	2,911	0	0	0	0	0	0	0	0	0	2,911	16
	C. General Administration													
17	Administrative	0	4,302	0	0	0	0	0	0	0	0	0	4,302	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(85,821)	0	0	0	0	0	0	0	0	0	(85,821)	19
20	Fees, Subscriptions & Promotions	(3,600)	0	59	0	0	0	0	0	0	0	0	(3,541)	20
21	Clerical & General Office Expenses	(16,859)	0	36,851	0	0	0	0	0	0	0	0	19,992	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	177	0	0	0	0	0	0	0	0	177	23
24	Travel and Seminar	0	0	8,218	0	0	0	0	0	0	0	0	8,218	24
25	Other Admin. Staff Transportation	0	0	3,793	0	0	0	0	0	0	0	0	3,793	25
26	Insurance-Prop.Liab.Malpractice	0	0	161	0	0	0	0	0	0	0	0	161	26
27	Other (specify):*	(21,356)	0	13,840	0	0	0	0	0	0	0	0	(7,516)	27
28	TOTAL General Administration	(41,815)	(81,519)	63,099	0	(60,235)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(41,901)	(80,763)	63,099	0	(59,565)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,971	0	301	24,932	0	0	0	0	0	0	0	33,204	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2)	0	1,603	69,220	0	0	0	0	0	0	0	70,821	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	9,063	(77,445)	0	0	0	0	0	0	0	(68,382)	34
35	Rent-Equipment & Vehicles	0	0	2,433	0	0	0	0	0	0	0	0	2,433	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	7,969	0	13,400	16,707	0	38,076	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)	(33,932)	(80,763)	76,499	16,707	0	(21,489)	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
		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	CONSULTING,
		LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES		BOOKKEEPING
SEE ATTACHED SCHEDULE		VANDALIA TERRACE	VANDALIA			
		PARKVIEW TERRACE	EAST MOLINE	SKYVIEW NURSING	SKOKIE, IL	REAL ESTATE
		SPRINGFIELD TERRACE	SPRINGFIELD	ASSOCIATES LTD		

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	\$ 10,536	MAVIN ENTERPRISES, LTD		\$	\$ (10,536)	1
2	V	10 PSYCHO-SOCIAL CONSULTANT	3,720				(3,720)	2
3	V	11 ACTIVITIES CONSULTANT	3,720				(3,720)	3
4	V	19 ADMIN. /BKPP. FEES	80,566				(80,566)	4
5	V	19 ADMIN. /CONSULT. FEES	7,416				(7,416)	5
6	V							6
7	V	5 ELECTRICITY/GAS				1,242	1,242	7
8	V	6 MAINTENANCE SALARIES				6,735	6,735	8
9	V	6 MAINTENANCE & REPAIR				344	344	9
10	V	7 SCAVENGER				60	60	10
11	V	10 PSYCH-SOCIAL & NURSING CONSULT				10,351	10,351	11
12	V	17 ADMINISTRATIVE SALARIES				4,302	4,302	12
13	V	19 PROFESSIONAL FEES				2,161	2,161	13
14	Total		\$ 105,958			\$ 25,195	\$ * (80,763)	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	20 ADVERTISING	\$	MAVIN ENTERPRISES, LTD		\$ 59	\$	59	15
16	V	21 TOTAL OFFICE				36,851		36,851	16
17	V	23 SEMINARS				177		177	17
18	V	24 TRAVEL				8,218		8,218	18
19	V	25 TRANSPORTATION				3,793		3,793	19
20	V	26 INSURANCE				161		161	20
21	V	27 EMPLOYEE BENEFITS				13,840		13,840	21
22	V	30 DEPRECIATION (SL)				301		301	22
23	V	32 INTEREST				1,603		1,603	23
24	V	34 OFFICE RENT				9,063		9,063	24
25	V	35 EQUIPMENT RENT				2,433		2,433	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		\$			\$ 76,499	\$ *	76,499	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	\$ 77,445	SKYVIEW NURSING ASSOCIATES		\$	(77,445)
16	V	30 DEPRECIATION				24,932	24,932
17	V	32 INTEREST				69,220	69,220
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 77,445			\$ 94,152	\$ * 16,707

* 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: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1									\$		1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8			SEE ATTACHED SCHEDULE									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: 01/01/2006 Ending: 2/31/2006

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 MAVIN ENTERPRISES, LTD
 Street Address 3745 OAKTON
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (647) 679-0100
 Fax Number (847) 679-0647

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	5	ELECTRICITY/GAS	PATIENT DAYS	126,554	6	\$ 9,240	\$ 17,012	\$ 1,242	1
2	6	MAINTENANCE SALARIES	PATIENT DAYS	126,554	6	50,100	50,100	17,012	6,735
3	6	MAINTENANCE & REPAIR	PATIENT DAYS	126,554	6	2,556	17,012	344	3
4	7	SCAVENGER	PATIENT DAYS	126,554	6	448	17,012	60	4
5	10	PSYCH-SOCIAL & NURSING C	PATIENT DAYS	126,554	6	77,000	17,012	10,351	5
6	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	126,554	6	32,000	32,000	17,012	4,302
7	19	PROFESSIONAL FEES	PATIENT DAYS	126,554	6	16,074	17,012	2,161	7
8	20	ADVERTISING	PATIENT DAYS	126,554	6	438	17,012	59	8
9	21	TOTAL OFFICE	PATIENT DAYS	126,554	6	274,137	224,827	17,012	36,851
10	23	SEMINARS	PATIENT DAYS	126,554	6	1,320	17,012	177	10
11	24	TRAVEL	PATIENT DAYS	126,554	6	61,135	17,012	8,218	11
12	25	TRANSPORTATION	PATIENT DAYS	126,554	6	28,213	17,012	3,793	12
13	26	INSURANCE	PATIENT DAYS	126,554	6	1,200	17,012	161	13
14	27	EMPLOYEE BENEFITS	PATIENT DAYS	126,554	6	102,955	17,012	13,840	14
15	30	DEPRECIATION (SL)	PATIENT DAYS	126,554	6	2,239	17,012	301	15
16	32	INTEREST	PATIENT DAYS	126,554	6	11,923	17,012	1,603	16
17	34	OFFICE RENT	PATIENT DAYS	126,554	6	67,423	17,012	9,063	17
18	35	EQUIPMENT RENT	PATIENT DAYS	126,554	6	18,096	17,012	2,433	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 756,497	\$ 306,927	\$ 101,694	25

Facility Name & ID Number

GOLDEN MOMENTS SENIOR CARE CEN

0036848

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$8,706.55	01/01/04	1,025,000	1,004,439		8.5000	69,220	3						
4												4						
5	MGMT CO ALLOCATION										1,603	5						
	Working Capital																	
6	BANK FINANCIAL	X		LINE OF CREDIT	DEMAND	06/99	150,000	213,975		PRIME+	15,831	6						
7												7						
8												8						
9	TOTAL Facility Related				\$8,706.55		\$ 1,175,000	\$ 1,218,414			\$ 86,654	9						
	B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 1,175,000	\$ 1,218,414			\$ 86,654	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.)

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 2005 report.		\$	27,805	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.)		\$	28,570	2
3. Under or (over) accrual (line 2 minus line 1).		\$	765	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	28,856	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.		\$	29,621	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	27,414	8
	2002	27,475	9
	2003	26,280	10
	2004	27,531	11
	2005	28,570	12

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 2005 TAX BILL.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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.

2005 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 2005 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 2005.

(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>28,570.02</u>	\$ <u>28,570.02</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>28,570.02</u>	\$ <u>28,570.02</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 GOLDEN MOMENTS SENIOR CARE CENTER

0036848

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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:

01/01/2006 Ending: 12/31/2006

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 BHF 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	\$	\$ 372,112	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	VARIOUS		1993	1,792	46	20	90	44	1,185	9
10	VARIOUS		1994	1,801	46	20	90	44	1,170	10
11	GENERATOR REPAIRS		1996	2,508	64	20	125	61	1,323	11
12	VENT REPAIRS		1996	1,200	31	20	60	29	605	12
13	ROOF REPAIRS		1997	50,700	1,300	20	2,535	1,235	24,294	13
14	PAINT & WALLPAPER		1997	21,655	555	20	1,082	527	10,189	14
15	REPLACEMENT SWITCH IN GENERATOR		1998	1,037	27	20	51	24	434	15
16	WALLPAPER, HARDWARE FOR WALLS		1998	5,613	144	20	280	136	2,380	16
17	HANDRAILS		1998	2,579	66	20	128	62	1,089	17
18	FLOOR & COVE BASE		1998	12,944	332	20	647	315	5,500	18
19	PAINTING /CARPETING		1998	9,995	256	20	499	243	4,242	19
20	ROOM SIGNS		1998	1,095	28	20	54	26	459	20
21	WALLPAPER		1999	5,374	138	20	268	130	2,144	21
22	HAND RAIL BUMPER, CAP		1999	5,034	129	20	251	122	2,008	22
23	SOFFIT INSULATION		1999	4,638	119	20	231	112	1,848	23
24	VCT INSTALLATION, FLOOR PATCH, TILE		1999	13,515	347	20	675	328	5,400	24
25	ROOM SIGNS, FRAMED ARTWORK		1999	3,685	94	20	184	90	1,472	25
26	HEATERS AND AIR CONDITIONING UNITS		2000	4,032	147	27.5	147		955	26
27	BUILT IN CABINETS FOR ADM. AND BOOKKEEPING OFFICE		2000	6,500	236	27.5	236		1,534	27
28	VCT INSTALLATION, COVE BASES, TILES, VINYL SHEET		2000	13,488	490	27.5	490		3,185	28
29	GUARD RAILS		2001	788	29	27.5	29		159	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)	\$	\$		\$	\$	\$	70
			955,345		29,556	33,084	3,528	443,687

**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	\$ 83,851	\$ 5,505	\$ 9,948	\$ 4,443	5-10 YRS	\$ 66,477	71
72	Current Year Purchases	2,240			0			72
73	Fully Depreciated Assets	74,225			0		74,225	73
74	MGMT ALLOCATION		301	301	0			74
75	TOTALS	\$ 160,316	\$ 5,806	\$ 10,249	\$ 4,443		\$ 140,702	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	FACILITY	1988 CHEVROLET	1993	\$ 9,422	\$	\$	\$ 0		\$ 9,422	76
77	FACILITY	1991 PLYMOUTH VOYAGER	1994	8,520			0		8,520	77
78							0			78
79							0			79
80	TOTALS			\$ 17,942	\$ 0	\$ 0	\$ 0		\$ 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)	\$ 1,177,235	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,362	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,333	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,971	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 602,331	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?

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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: \$ 14,282 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	\$ 849.89	\$ 3,400	17
18	FACILITY	2006 FORD VAN	673.63	5,389	18
19					19
20					20
21	TOTAL		\$ #####	\$ 8,789	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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$		\$ 47,374	\$		\$ 47,374	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,407			1,407	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			32,192			32,192	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 prescripts				46,384		46,384	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): MEDICAL SUPPLIES	39-2					6,878		6,878	13
14	TOTAL			\$		\$ 80,973	\$ 53,262		\$ 134,235	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 GOLDEN MOMENTS SENIOR CARE CENTER

0036848

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ (50,442)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	530,308		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,313		6
7	Other Prepaid Expenses	16,233		7
8	Accounts Receivable (owners or related parties)	907,746		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,424,158	\$ 0	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	134,658		16
17	Accumulated Depreciation (book methods)	(171,857)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	7,916		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 152,321	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,576,479	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 631,571	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,877,075		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	70,167		31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,856		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)	\$ 2,607,669	\$ 0	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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,607,669	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,031,190)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,576,479	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (845,320)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(5,788)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (851,108)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(180,082)	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)	\$ (180,082)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,031,190)	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	\$ 1,680,150	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,680,150	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	38,238	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 38,238	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2	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)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,718,390	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	348,517	31
32	Health Care	732,061	32
33	General Administration	465,694	33
	B. Capital Expense		
34	Ownership	156,097	34
	C. Ancillary Expense		
35	Special Cost Centers	134,235	35
36	Provider Participation Fee	61,868	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,898,472	40
41	Income before Income Taxes (line 30 minus line 40)**	(180,082)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (180,082)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO 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: 01/01/2006

Ending: 12/31/2006

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	1,808	2,003	\$ 45,584	\$ 22.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,838	1,965	41,491	21.12	3
4	Licensed Practical Nurses	10,864	11,421	190,599	16.69	4
5	CNAs & Orderlies	33,565	34,399	329,937	9.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,328	2,421	21,701	8.96	10
11	Social Service Workers	1,831	1,848	23,210	12.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,681	9,265	81,153	8.76	15
16	Dishwashers					16
17	Maintenance Workers	1,801	1,920	19,384	10.10	17
18	Housekeepers	5,232	5,460	41,667	7.63	18
19	Laundry	2,098	2,309	15,440	6.69	19
20	Administrator	1,808	1,966	59,983	30.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,747	1,892	24,598	13.00	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 <u>Care Plan Coordin</u>	1,387	1,493	25,879	17.33	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	74,988	78,362	\$ 920,626 *	\$ 11.75	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	\$ 4,407	1-3	35
36	Medical Director	O	11,500	9-3	36
37	Medical Records Consultant	N	251	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	600	10-3	39
40	Physical Therapy Consultant	L	1,921	10a-3	40
41	Occupational Therapy Consultant	Y	344	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,720	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) <u>Geriatric Consultant</u>	S	1,073	10-3	46
47	<u>Dental</u>		860	10-3	47
48	<u>Psycho Social</u>		6,720	10-3	48
49	TOTAL (lines 35 - 48)		\$ 31,396		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	Certified Nurse Assistants/Aides			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	
MARSHA JACOBS	ADMINISTRATOR	0.00%	\$ 16,329	Workers' Compensation Insurance	\$ 49,360	IDPH License Fee	\$	
GLENN MILLER	ADMINISTRATOR	0.00%	43,654	Unemployment Compensation Insurance	23,365	Advertising: Employee Recruitment	2,616	
				FICA Taxes	73,993	Health Care Worker Background Check	270	
				Employee Health Insurance	14,043	(Indicate # of checks performed <u>27</u>)		
				Employee Meals	0	Patient Background Checks	53	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	380	
				EMPLOYEE BENEFITS - OTHER	2,894	MARKETING/ADV/PROMO	3,220	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	6,914	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	59	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(380)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(3,220)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 59,983	TOTAL (agree to Schedule V, line 22, col.8)	\$ 163,655	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,389	
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
MELVIN SIEGEL	MANAGEMENT FEES		\$ 3,000				Out-of-State Travel	\$
							In-State Travel	
								175
							MGMT CO ALLOC	8,218
							Seminar Expense	
								740
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 3,000	TOTAL			(agree to Sch. V, line 24, col. 8)	\$ 9,133
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			132,483					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 132,483					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER# 0036848Report Period Beginning: 01/01/2006Ending: 12/31/2006**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 ON LONG TERM CARE \$6576
- (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? _____
- (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. \$ 0 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 during this cost report period. \$ 61,868
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
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