		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0036848

Facility Name: GOLDEN MOMENTS SENIOR CARE CENTER

Address: 1021 NORTH CHURCH STREET (Number) JACKSONVILLE (City) 62650 (Zip Code)

County: MORGAN

Telephone Number: (217) 245-4174 **Fax #** (217) 243-5901

HFS ID Number: 36-1274300

Date of Initial License for Current Owners: 01/31/91

Type of Ownership:

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2009 to 12/31/2009 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) (Date) (Type or Print Name) MELVIN SIEGEL (Title) PRESIDENT
Paid Preparer	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date) (Print Name and Title) BOB KAGDA, VICE PRESIDENT (Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124 (Telephone) (847) 675-3585 Fax # (847) 675-5777

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	113	Intermediate (ICF)	113	41,245	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			967	967	8
9	SNF/PED					9
10	ICF	17,396	1,181		18,577	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,396	1,181	967	19,544	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.39%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/31/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/31/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 23 and days of care provided 967

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CEN # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	118,980	6,017	5,340	130,337		130,337		130,337			1
2	Food Purchase		98,402		98,402		98,402	(239)	98,163			2
3	Housekeeping	76,952	11,903		88,855		88,855		88,855			3
4	Laundry	11,657	4,528		16,185		16,185		16,185			4
5	Heat and Other Utilities			87,725	87,725		87,725	140	87,865			5
6	Maintenance	27,181		38,204	65,385		65,385	109	65,494			6
7	Other (specify):*			8,168	8,168		8,168	1	8,169			7
8	TOTAL General Services	234,770	120,850	139,437	495,057		495,057	11	495,068			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	1,020,602	35,747	15,587	1,071,936		1,071,936	(3,509)	1,068,427			10
10a	Therapy			122	122		122		122			10a
11	Activities	21,780	2,041	4,728	28,549		28,549	(3,720)	24,829			11
12	Social Services	71,223			71,223		71,223		71,223			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,113,605	37,788	31,237	1,182,630		1,182,630	(7,229)	1,175,401			16
	C. General Administration											
17	Administrative	119,507			119,507		119,507		119,507			17
18	Directors Fees											18
19	Professional Services			119,927	119,927		119,927	(55,609)	64,318			19
20	Dues, Fees, Subscriptions & Promotions			14,529	14,529		14,529	(670)	13,859			20
21	Clerical & General Office Expenses	19,125	8,169	15,036	42,330		42,330	32,239	74,569			21
22	Employee Benefits & Payroll Taxes			222,873	222,873		222,873		222,873			22
23	Inservice Training & Education							207	207			23
24	Travel and Seminar			1,886	1,886		1,886	6,503	8,389			24
25	Other Admin. Staff Transportation			4,624	4,624		4,624	2,885	7,509			25
26	Insurance-Prop.Liab.Malpractice			8,560	8,560		8,560		8,560			26
27	Other (specify):*			30,936	30,936		30,936	(22,583)	8,353			27
28	TOTAL General Administration	138,632	8,169	418,371	565,172		565,172	(37,028)	528,144			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,487,007	166,807	589,045	2,242,859		2,242,859	(44,246)	2,198,613			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.

Facility Name & ID#: GOLDEN MOMENTS SENIOR CARE CENTER #0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,340	
	REPAIRS & MAINTENANCE		0	
			0	5,340
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		8,736	
	ELECTRICITY		55,611	
	WATER		14,698	
	CABLE TV - LOBBY		8,680	
			0	87,725
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,363	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE CONSULTANT		10,536	
	EQUIPMENT MAINTENANCE & REPAIR		22,532	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		1,773	
			0	
			0	
			0	
			0	38,204
7	**OTHER**			
	SCAVENGER & EXTERMINATING SERVICI		5,655	
	SECURITY SERVICE		2,513	
			0	
			0	8,168
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	10,800	10,800

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		7,109	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	5,698	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	540	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	2,240	
			0	
			0	15,587
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		61	
	OCCUPATIONAL THERAPY SERVICES		61	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				122
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,728	
			0	4,728
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	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

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER #0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,343	
	ADMINISTRATIVE CONSULTANTS	XIX C	7,416	
	PROFESSIONAL FEES	XIX C	32,034	
	BOOOKKEEPING/ADMINISTRATIVE SERVICE		68,134	119,927
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	240	
	EMPLOYEE WANT ADS	XIX F	1,800	
	CONTRIBUTIONS	VI 20 XIX F	530	
	DUES & SUBSCRIPTIONS	XIX F	9,773	
	LICENSES & PERMITS	XIX F	1,416	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	510	
	PATIENT BACKGROUND CHECKS	XIX F	260	
				14,529
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		830	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	3,856	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		2,320	
	TELEPHONE		7,974	
	MESSENGER SERVICE		56	
			0	15,036

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	111,540	
	UNEMPLOYMENT COMPENSATION	XIX D	35,095	
	WORKERS COMPENSATION INSURANC	XIX D	54,025	
	HOSPITALIZATION INSURANCE	XIX D	21,637	
	EMPLOYEE BENEFITS - OTHER	XIX D	576	
	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	222,873
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,886	
	TRAVEL	XIX G	0	
				1,886
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,624	
				4,624
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		8,560	
				8,560
27	**OTHER**			
	BAD DEBTS	VI 24	30,936	
				30,936

GRAND TOTAL COLUMN 3 OTHER **589,045**

GOLDEN MOMENTS SENIOR CARE CENTER
SCHEDULES
12/31/2009

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	98,402
LESS SALES TAX	(239)
NET FOOD	98,163
TOTAL PATIENT CENSUS	19,544
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	58,632
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	58,632
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	58,632
NET FOOD	98,163
DIVIDE TOTAL MEALS/YEAR	58,632
COST PER MEAL	1.67
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER #0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			6,152	6,152		6,152	28,945	35,097			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,395	2,395		2,395	52,939	55,334			32
33	Real Estate Taxes			32,201	32,201		32,201		32,201			33
34	Rent-Facility & Grounds			60,892	60,892		60,892	(56,146)	4,746			34
35	Rent-Equipment & Vehicles			13,162	13,162		13,162	5,316	18,478			35
36	Other (specify):*											36
37	TOTAL Ownership			114,802	114,802		114,802	31,054	145,856			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,313	188,310	228,623		228,623		228,623			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		40,313	250,177	290,490		290,490		290,490			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,487,007	207,120	954,024	2,648,151		2,648,151	(13,192)	2,634,959			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: 01/01/2009 Ending: 12/31/2009

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,976	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(239)	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	(3,856)	21		18
19	Entertainment		20		19
20	Contributions	(530)	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	(30,936)	27		24
25	Fund Raising, Advertising and Promotional	(240)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (31,826)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	18,634		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 18,634		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (13,192)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

GOLDEN MOMENTS SENIOR CARE CENTER

ID# 0036848

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(239)	0	0	0	0	0	0	0	0	0	0	(239)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	140	0	0	0	0	0	0	0	0	140	5
6	Maintenance	0	(10,536)	10,645	0	0	0	0	0	0	0	0	109	6
7	Other (specify):*	0	0	1	0	0	0	0	0	0	0	0	1	7
8	**TOTAL General Services**	(239)	(10,536)	10,786	0	0	0	0	0	0	0	0	11	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	(3,720)	211	0	0	0	0	0	0	0	0	(3,509)	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	(7,440)	211	0	0	0	0	0	0	0	0	(7,229)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(56,846)	1,237	0	0	0	0	0	0	0	0	(55,609)	19
20	Fees, Subscriptions & Promotions	(770)	0	100	0	0	0	0	0	0	0	0	(670)	20
21	Clerical & General Office Expenses	(3,856)	0	36,095	0	0	0	0	0	0	0	0	32,239	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	207	0	0	0	0	0	0	0	0	207	23
24	Travel and Seminar	0	0	6,503	0	0	0	0	0	0	0	0	6,503	24
25	Other Admin. Staff Transportation	0	0	2,885	0	0	0	0	0	0	0	0	2,885	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(30,936)	0	8,353	0	0	0	0	0	0	0	0	(22,583)	27
28	**TOTAL General Administration**	(35,562)	(56,846)	55,380	0	0	0	0	0	0	0	0	(37,028)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,801)	(74,822)	66,377	0	0	0	0	0	0	0	0	(44,246)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	3,976	0	37	24,932	0	0	0	0	0	0	0	28,945	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1)	0	79	52,861	0	0	0	0	0	0	0	52,939	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	4,746	(60,892)	0	0	0	0	0	0	0	(56,146)	34
35	Rent-Equipment & Vehicles	0	0	5,316	0	0	0	0	0	0	0	0	5,316	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	3,975	0	10,178	16,901	0	0	0	0	0	0	0	31,054	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)	(31,826)	(74,822)	76,555	16,901	0	0	0	0	0	0	0	(13,192)	45

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 LIST		VANDALIA TERRACE	VANDALIA			
		SPRINGFIELD TERRACE	SPRINGFIELD	SKYVIEW NURSING	SKOKIE, IL	REAL ESTATE
				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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE CONSULTAN	$ 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. /BKKP. FEES	49,430				(49,430)	4
5	V	19	ADMIN. /CONSULT. FEES	7,416				(7,416)	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 74,822			$	$ * (74,822)	14

* 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: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

	1	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	5	ELECTRICITY/GAS	$	MAVIN ENTERPRISES, LTD		$ 140	$ 140	15
16	V	6	MAINTENANCE SALARIES				10,594	10,594	16
17	V	6	MAINTENANCE & REPAIR				51	51	17
18	V	7	SCAVENGER				1	1	18
19	V	10	PSYCHO-SOCIAL & NURSING CONSULT				211	211	19
20	V	19	PROFESSIONAL FEES				1,237	1,237	20
21	V	20	ADVERTISING				100	100	21
22	V	21	TOTAL OFFICE				36,095	36,095	22
23	V	23	SEMINARS				207	207	23
24	V	24	TRAVEL				6,503	6,503	24
25	V	25	TRANSPORTATION				2,885	2,885	25
26	V	27	EMPLOYEE BENEFITS				8,353	8,353	26
27	V	30	DEPRECIATION (SL)				37	37	27
28	V	32	INTEREST				79	79	28
29	V	34	OFFICE RENT				4,746	4,746	29
30	V	35	EQUIPMENT RENT				5,316	5,316	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			$			$ 76,555	$ * 76,555	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: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 60,892	SKYVIEW NURSING ASSOCIATES		$	$ (60,892)	15
16	V	30	DEPRECIATION				24,932	24,932	16
17	V	32	INTEREST				52,861	52,861	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			$ 60,892			$ 77,793	$ * 16,901	39

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

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CE # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	MELVIN SIEGEL	PRESIDENT	ADMINISTR.	14.80	SEE ATTACHED			SALARY	$ 16,500	17-1	1
2					SCHEDULE						2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 16,500		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: 01/01/2009 Ending: 2/31/2009

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY/GAS	PATIENT DAYS	92,429	5	$ 662	$	19,544	$ 140	1
2	6	MAINTENANCE SALARIES	PATIENT DAYS	92,429	5	50,100	50,100	19,544	10,594	2
3	6	MAINTENANCE & REPAIR	PATIENT DAYS	92,429	5	241		19,544	51	3
4	7	SCAVENGER	PATIENT DAYS	92,429	5	6		19,544	1	4
5	10	PSYCHO-SOCIAL & NURSING	PATIENT DAYS	92,429	5	1,000		19,544	211	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	92,429	5	5,848		19,544	1,237	6
7	20	ADVERTISING	PATIENT DAYS	92,429	5	472		19,544	100	7
8	21	TOTAL OFFICE	PATIENT DAYS	92,429	5	170,703	132,625	19,544	36,095	8
9	23	SEMINARS	PATIENT DAYS	92,429	5	980		19,544	207	9
10	24	TRAVEL	PATIENT DAYS	92,429	5	30,753		19,544	6,503	10
11	25	TRANSPORTATION	PATIENT DAYS	92,429	5	13,644		19,544	2,885	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	92,429	5	39,504		19,544	8,353	12
13	30	DEPRECIATION (SL)	PATIENT DAYS	92,429	5	173		19,544	37	13
14	32	INTEREST	PATIENT DAYS	92,429	5	375		19,544	79	14
15	34	OFFICE RENT	PATIENT DAYS	92,429	5	22,445		19,544	4,746	15
16	35	EQUIPMENT RENT	PATIENT DAYS	92,429	5	25,141		19,544	5,316	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 362,047	$ 182,725		$ 76,555	25

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CEN # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY:						$	$			$	1
2	SKYVIEW NURSING ASSOCIATES											2
3	BANK FINANCIAL		X	MORTGAGE	$8,664.63	01/01/04	1,025,000	991,150			52,861	3
4												4
5	MGMT ALLOCATION										79	5
	Working Capital											
6	BANK FINANCIAL		X	LINE OF CREDIT	DEMAND	06/99	150,000	312,227		PRIME+	2,395	6
7												7
8												8
9	TOTAL Facility Related				$8,664.63		$ 1,175,000	$ 1,303,377			$ 55,335	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,175,000	$ 1,303,377			$ 55,335	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.)

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

1. Real Estate Tax accrual used on 2008 report.	$ 29,204	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.)	$ 30,550	2
3. Under or (over) accrual (line 2 minus line 1).	$ 1,346	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 30,855	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.	$ 32,201	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2004	27,531	8
2005	28,570	9
2006	29,992	10
2007	28,915	11
2008	30,550	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 2008 TAX BILL

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	$	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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-17-204-013	NURSING HOME	$ 30,549.50	$ 30,549.50
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 30,549.50	$ 30,549.50

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES ___X___ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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: 01/01/2009 Ending: 12/31/2009

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1991	$ 43,632	1
2					2
3	TOTALS			$ 43,632	3

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	113		1991		$ 785,372	$ 24,932	31.5	$ 24,932	$	$ 446,908	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1993	1,792	46	20	90	44	1,455	9
10	VARIOUS			1994	1,801	46	20	90	44	1,440	10
11	GENERATOR REPAIRS			1996	2,508	64	20	125	61	1,698	11
12	VENT REPAIRS			1996	1,200	31	20	60	29	785	12
13	ROOF REPAIRS			1997	50,700	1,300	20	2,535	1,235	31,899	13
14	PAINT & WALLPAPER			1997	21,655	555	20	1,082	527	13,435	14
15	REPLACEMENT SWITCH IN GENERATOR			1998	1,037	27	20	51	24	587	15
16	WALLPAPER, HARDWARE FOR WALLS			1998	5,613	144	20	280	136	3,220	16
17	HANDRAILS			1998	2,579	66	20	128	62	1,473	17
18	FLOOR & COVE BASE			1998	12,944	332	20	647	315	7,441	18
19	PAINTING /CARPETING			1998	9,995	256	20	499	243	5,739	19
20	ROOM SIGNS			1998	1,095	28	20	54	26	621	20
21	WALLPAPER			1999	5,374	138	20	268	130	2,948	21
22	HAND RAIL BUMPER, CAP			1999	5,034	129	20	251	122	2,761	22
23	SOFFIT INSULATION			1999	4,638	119	20	231	112	2,541	23
24	VCT INSTALLATION, FLOOR PATCH, TILE			1999	13,515	347	20	675	328	7,425	24
25	ROOM SIGNS, FRAMED ARTWORK			1999	3,685	94	20	184	90	2,024	25
26	HEATERS AND AIR CONDITIONING UNITS			2000	4,032	147	27.5	147		1,396	26
27	BUILT IN CABINETS FOR ADM. AND BOOKKEEPING OFFICE			2000	6,500	236	27.5	236		2,242	27
28	VCT INSTALLATION,COVE BASES, TILES,VINYL SHEET			2000	13,488	490	27.5	490		4,655	28
29	GUARD RAILS			2001	788	29	27.5	29		246	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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	$ 29,556		$ 33,084	$ 3,528	$ 542,939	70

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

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	$ 16,386	$ 1,528	$ 1,976	$ 448	5-10	$ 6,943	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	116,493					116,493	73
74	MGMT ALLOCATION		37	37				74
75	TOTALS	$ 132,879	$ 1,565	$ 2,013	$ 448		$ 123,436	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	$	$	$		$ 9,422	76
77	FACILITY	1991 PLYMOUTH VOYAGER	1994	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)	$ 1,149,798	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 31,121	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 35,097	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,976	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 684,317	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.

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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: _____ *

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.		$
13.		$
14.		$

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: $ 4,550 Description: DISHWASHER - $2,162; COPIER - $2,388
(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	2006 FORD VAN	$ 685.76	$ 8,612	17
18					18
19					19
20					20
21	TOTAL		$ 685.76	$ 8,612	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 87,787	$		$ 87,787	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,764			7,764	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			92,759			92,759	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				29,097		29,097	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): MEDICAL SUPPLIES	39-2					11,216		11,216	13
14	TOTAL			$		$ 188,310	$ 40,313		$ 228,623	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: 01/01/2009 Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2009 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,041	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	691,231		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,482		6
7	Other Prepaid Expenses	12,084		7
8	Accounts Receivable (owners or related parties)	584,269		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,307,107	$	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	139,190		16
17	Accumulated Depreciation (book methods)	(193,869)		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)**	$ 126,925	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,434,032	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 450,881	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,309,186		29
30	Accrued Salaries Payable	63,861		30
31	Accrued Taxes Payable (excluding real estate taxes)	168,296		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,855		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)**	$ 3,023,079	$	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)**	$ 3,023,079	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,589,047)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,434,032	$	48

*(See instructions.)

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,381,743)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(7,002)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,388,745)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(200,302)	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)**	$ (200,302)	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)**	$ (1,589,047)	24 *

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

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,447,848	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,447,848	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1	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)**	$ 2,447,849	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	495,057	31
32	Health Care	1,182,630	32
33	General Administration	565,172	33
	B. Capital Expense		
34	Ownership	114,802	34
	C. Ancillary Expense		
35	Special Cost Centers	228,623	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)***	$ 2,648,151	40
41	**Income before Income Taxes (line 30 minus line 40)****	(200,302)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (200,302)	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: 01/01/2009 Ending: 12/31/2009

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	936	968	$ 38,347	$ 39.61	1
2	Assistant Director of Nursing	224	320	10,497	32.80	2
3	Registered Nurses	617	625	20,599	32.96	3
4	Licensed Practical Nurses	16,812	17,530	372,585	21.25	4
5	CNAs & Orderlies	46,840	47,499	530,855	11.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,374	2,438	21,780	8.93	10
11	Social Service Workers	3,608	3,901	71,223	18.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,197	12,122	118,980	9.82	15
16	Dishwashers					16
17	Maintenance Workers	2,377	2,558	27,181	10.63	17
18	Housekeepers	7,930	8,315	76,952	9.25	18
19	Laundry	1,276	1,307	11,657	8.92	19
20	Administrator	2,008	2,080	46,817	22.51	20
21	Assistant Administrator	2,000	2,080	56,190	27.01	21
22	Other Administrative	525	525	16,500	31.43	22
23	Office Manager					23
24	Clerical	1,663	1,889	19,125	10.12	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 Ca Care Plan Coord	2,024	2,112	47,719	22.59	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	102,411	106,269	$ 1,487,007 *	$ 13.99	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	$ 5,340	1-3	35
36	Medical Director	O	10,800	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	2,240	10-3	38
39	Pharmacist Consultant	H	540	10-3	39
40	Physical Therapy Consultant	L	0	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	4,728	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 23,648		49

C. CONTRACT NURSES

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

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARY M. POZZO	ADMINISTRATOR	0	$ 46,817
CHRISTOFER ROBB	ASST ADMIN	0	56,190
MELVIN SIEGEL	PRESIDENT	14.8	16,500
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 119,507

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
NURSING CARE SYATEMS	DATA PROCESSING	$ 7,205
ALPHA DATA SERVICES	DATA PROCESSING	3,638
LTC SOLUTIONS, INC	DATA PROCESSING	1,500
HEPLER BROOM MACDONALD	LEGAL FEES	2,106
KRUPNICK, BOKOR,KAGDA	ACCOUNTING FEES	9,875
PERSONNEL PLANNERS	UC CONSULTANT	2,050
MAVIN ENTERPRISES	BOOKKEEPING/ADMIN	68,134
MAVIN ENTERPRISES	ADMIN. CONSULTANT	7,416
RICHARD PEELO	MEDICARE CONSULTANT	4,200
SHARON HAUGH	MEDICARE CONSULTANT	3,000
STRATTON,GIGANTI, STONE	LEGAL FEES	4,755
KOPEC & WHITE	LEGAL FEES	6,048
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 119,927

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,025
Unemployment Compensation Insurance	35,095
FICA Taxes	111,540
Employee Health Insurance	21,637
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	576
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 222,873

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	1,800
Health Care Worker Background Check	510
(Indicate # of checks performed 51)	
Patient Background Checks 26	260
TRUST/FRANCHISE/CONTRIB/ETC	530
MARKETING/ADV/PROMO	240
LICENSES/DUES/SUBSCRIPTIONS	10,194
MGMT CO ALLOC	100
TRUST/FRANCHISE/CONTRIB/ETC	(530)
Less: Public Relations Expense	(0)
Non-allowable advertising	(240)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,859

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOC	6,503
Seminar Expense	
	1,886
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,389

**See instructions.

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7							N/A						
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GOLDEN MOMENTS SENIOR CARE CENTER # 0036848 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $9,289**

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

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

(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 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, 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:

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

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