

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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 Facility ID Number:** 0027961

**Facility Name:** Nokomis Golden Manor

**Address:** 505 Stevens Street Nokomis 62075  
 Number City Zip Code

**County:** Montgomery

**Telephone Number:** (217) 563-7725 **Fax #** (217) 563-2022

**HFS ID Number:** 37-1128552-1

**Date of Initial License for Current Owners:** 04/01/1983

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Cindy A. Tefteller **Telephone Number:** (618) 465-7717

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 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) \_\_\_\_\_

(Title) \_\_\_\_\_

**Paid Preparer**

(Signed) Compilation Report Attached (Date) \_\_\_\_\_

(Print Name and Title) Cindy A. Tefteller  
Partner

(Firm Name & Address) C.J. Schlosser & Company, L.L.C.  
233 East Center Drive, Alton, IL 62002

(Telephone) (618) 465-7717 Fax # (618) 465-7710

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor

# 0027961 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	<u>92</u>	Skilled (SNF)	<u>92</u>	<u>33,580</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>92</u>	TOTALS	<u>92</u>	<u>33,580</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>753</u>	<u>73</u>	<u>2,073</u>	<u>2,899</u>	8
9	SNF/PED					9
10	ICF	<u>14,662</u>	<u>4,224</u>		<u>18,886</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,415</u>	<u>4,297</u>	<u>2,073</u>	<u>21,785</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.87%

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 04/01/1983

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/01/1983 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 12 and days of care provided 2,073

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL  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 Nokomis Golden Manor # 0027961 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
	<b>A. General Services</b>										
1	Dietary	100,037	10,755	8,344	119,136	41	119,177		119,177		1
2	Food Purchase		103,380		103,380		103,380	(1,010)	102,370		2
3	Housekeeping	49,731	12,382		62,113	274	62,387		62,387		3
4	Laundry	47,857	13,072		60,929	90	61,019		61,019		4
5	Heat and Other Utilities			86,481	86,481		86,481	644	87,125		5
6	Maintenance	23,684	26,537	1,100	51,321		51,321	23,579	74,900		6
7	Other (specify):* <b>Sanitation</b>			2,825	2,825		2,825		2,825		7
8	<b>TOTAL General Services</b>	<b>221,309</b>	<b>166,126</b>	<b>98,750</b>	<b>486,185</b>	<b>405</b>	<b>486,590</b>	<b>23,213</b>	<b>509,803</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,625	1,625		1,625		1,625		9
10	Nursing and Medical Records	1,010,702	39,205	8,529	1,058,436	(446)	1,057,990		1,057,990		10
10a	Therapy			441,490	441,490		441,490		441,490		10a
11	Activities	17,229	2,359	2,341	21,929		21,929		21,929		11
12	Social Services	25,860			25,860		25,860		25,860		12
13	CNA Training										13
14	Program Transportation			1,504	1,504		1,504		1,504		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,053,791</b>	<b>41,564</b>	<b>455,489</b>	<b>1,550,844</b>	<b>(446)</b>	<b>1,550,398</b>		<b>1,550,398</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	67,737	26,913		94,650	(2,379)	92,271	55,250	147,521		17
18	Directors Fees										18
19	Professional Services			18,535	18,535		18,535	3,166	21,701		19
20	Dues, Fees, Subscriptions & Promotions			13,548	13,548	1,879	15,427	(8,272)	7,155		20
21	Clerical & General Office Expenses	26,614	14,604	17,119	58,337	41	58,378	29,097	87,475		21
22	Employee Benefits & Payroll Taxes			273,427	273,427	500	273,927	8,584	282,511		22
23	Inservice Training & Education			363	363		363		363		23
24	Travel and Seminar			1,025	1,025		1,025	536	1,561		24
25	Other Admin. Staff Transportation							1,787	1,787		25
26	Insurance-Prop.Liab.Malpractice			49,157	49,157		49,157	(5,044)	44,113		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>94,351</b>	<b>41,517</b>	<b>373,174</b>	<b>509,042</b>	<b>41</b>	<b>509,083</b>	<b>85,104</b>	<b>594,187</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,369,451</b>	<b>249,207</b>	<b>927,413</b>	<b>2,546,071</b>		<b>2,546,071</b>	<b>108,317</b>	<b>2,654,388</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Nokomis Golden Manor #0027961 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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	
	<b>D. Ownership</b>											
30	Depreciation			75,249	75,249		75,249	(10,486)	64,763			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			40,893	40,893		40,893	587	41,480			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			116,142	116,142		116,142	(9,899)	106,243			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,537	4,898	58,435		58,435		58,435			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,370	50,370		50,370		50,370			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		53,537	55,268	108,805		108,805		108,805			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,369,451	302,744	1,098,823	2,771,018		2,771,018	98,418	2,869,436			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor

# 0027961

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				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	(1,010)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(19,600)	17		18
19	Entertainment	(3,120)	17		19
20	Contributions	(68)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,320)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(461)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(71)	17		28
29	Other-Attach Schedule	(22,024)	VAR		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (54,674)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	153,092	VAR	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 153,092		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 98,418		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Nokomis Golden Manor

ID# 0027961

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Adjust for depr req'd to be capitalized for cost rpt	\$ (15,611)	30
2	Offset liability insurance dividend received	(6,413)	26
3			
4			
5			
6			
7			
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49	<b>Total</b>	(22,024)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Nokomis Golden Manor

# 0027961

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,010)	0	0	0	0	0	0	0	0	0	0	(1,010)	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	644	0	0	0	0	0	0	0	0	0	644	5
6	Maintenance	0	23,579	0	0	0	0	0	0	0	0	0	23,579	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,010)</b>	<b>24,223</b>	<b>0</b>	<b>23,213</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(22,791)	78,041	0	0	0	0	0	0	0	0	0	55,250	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,166	0	0	0	0	0	0	0	0	0	3,166	19
20	Fees, Subscriptions & Promotions	(8,388)	116	0	0	0	0	0	0	0	0	0	(8,272)	20
21	Clerical & General Office Expenses	(461)	29,558	0	0	0	0	0	0	0	0	0	29,097	21
22	Employee Benefits & Payroll Taxes	0	8,584	0	0	0	0	0	0	0	0	0	8,584	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	536	0	0	0	0	0	0	0	0	0	536	24
25	Other Admin. Staff Transportation	0	1,787	0	0	0	0	0	0	0	0	0	1,787	25
26	Insurance-Prop.Liab.Malpractice	(6,413)	1,369	0	0	0	0	0	0	0	0	0	(5,044)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(38,053)</b>	<b>123,157</b>	<b>0</b>	<b>85,104</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(39,063)</b>	<b>147,380</b>	<b>0</b>	<b>108,317</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number Nokomis Golden Manor

# 0027961

Report Period Beginning:

01/01/2006 Ending:

Summary B

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(15,611)	5,125	0	0	0	0	0	0	0	0	0	(10,486)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	587	0	0	0	0	0	0	0	0	0	587	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(15,611)</b>	<b>5,712</b>	<b>0</b>	<b>(9,899)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(54,674)</b>	<b>153,092</b>	<b>0</b>	<b>98,418</b>	<b>45</b>								

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jerry & Marilyn King	100.00	Mt. Vernon Countryside Manor	Mt. Vernon	King Management	Nashville	Home Office
Jerry & Marilyn King	100.00	Taylorville Care Center, Inc.	Taylorville			
Jerry & Marilyn King	100.00	Aviston Countryside Manor	Aviston			

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	5 See Schedule VIII	\$	King Management Co.	100.00%	\$ 644	\$ 644	1
2	V	6 See Schedule VIII		King Management Co.	100.00%	23,579	23,579	2
3	V	17 See Schedule VIII		King Management Co.	100.00%	78,041	78,041	3
4	V	19 See Schedule VIII		King Management Co.	100.00%	3,166	3,166	4
5	V	20 See Schedule VIII		King Management Co.	100.00%	116	116	5
6	V	21 See Schedule VIII		King Management Co.	100.00%	29,558	29,558	6
7	V	22 See Schedule VIII		King Management Co.	100.00%	8,584	8,584	7
8	V	24 See Schedule VIII		King Management Co.	100.00%	536	536	8
9	V	25 See Schedule VIII		King Management Co.	100.00%	1,787	1,787	9
10	V	26 See Schedule VIII		King Management Co.	100.00%	1,369	1,369	10
11	V	30 See Schedule VIII		King Management Co.	100.00%	5,125	5,125	11
12	V	33 See Schedule VIII		King Management Co.	100.00%	587	587	12
13	V							13
14	Total		\$			\$ 153,092	\$ * 153,092	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor # 0027961 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	Jerry King	Owner	Mgmt/Consultant	100.00	65,701	11	19.10	Salary	\$ 15,512	17,8	1
2	Denise King	Regional Director	Administrative	0.00	252,609	11	19.10	Salary	59,640	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00	67,353	10	19.10	Salary	15,902	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00	223,372	0	0.00	Salary	0	N/A	4
5	Elizabeth King	Dietary	Dietary	0.00	2,448	0	0.00	Salary	0	N/A	5
6	Marilyn King	Owner	Mgmt/Consultant	100.00	3,236	1	19.10	Salary	764	17,8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 91,818		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor

# 0027961

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

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

Name of Related Organization King Management Company  
 Street Address 935 Mill Street  
 City / State / Zip Code Nashville, IL 62263  
 Phone Number (618) 327-3064  
 Fax Number (618) 327-3083

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	Utilities	Patient Days	114,030	4	\$ 3,370	\$ 21,780	\$ 644	1	
2	6	Maintenance	Patient Days	114,030	4	123,448	83,255	21,780	23,579	2
3	17	Administrative	Patient Days	114,030	4	408,584	397,462	21,780	78,041	3
4	19	Professional Fees	Patient Days	114,030	4	16,578	21,780	3,166	4	
5	20	Dues, Fees, & Subscriptions	Patient Days	114,030	4	609	21,780	116	5	
6	21	Clerical and Office Expense	Patient Days	114,030	4	154,752	137,932	21,780	29,558	6
7	22	Employee Benefits	Patient Days	114,030	4	44,942	21,780	8,584	7	
8	24	Travel & Seminar	Patient Days	114,030	4	2,804	21,780	536	8	
9	25	Other Admin. Staff Transp.	Patient Days	114,030	4	9,354	21,780	1,787	9	
10	26	Insurance	Patient Days	114,030	4	7,167	21,780	1,369	10	
11	30	Depreciation-Other	Patient Days	114,030	4	12,760	21,780	2,437	11	
12	30	Deprciation-Autos	Patient Days	114,030	4	14,071	21,780	2,688	12	
13	33	Real Estate Taxes	Patient Days	114,030	4	3,074	21,780	587	13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 801,513	\$ 618,649	\$ 153,092	25	

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Schedule Not Applicable						\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	15

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

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2005 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>41,000</b>	<b>1</b>
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.)		2005	\$	<b>40,893</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(107)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>41,000</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>40,893</b>	<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2001	<u>32,871</u>	<u>8</u>			
2002	<u>35,399</u>	<u>9</u>			
2003	<u>39,092</u>	<u>10</u>			
2004	<u>40,205</u>	<u>11</u>			
2005	<u>40,893</u>	<u>12</u>			
<b>Line 4: Accrual is based on 2005 taxes paid.</b>		<b>Line 7: Real Estate Tax</b>		<b>40,893</b>	
		<b>Home Office Allocation</b>		<b>587</b>	
		<b>Schedule V Real Estate Tax</b>		<b>41,480</b>	
			<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$		<b>13</b>	
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$		<b>14</b>	
<b>15</b>	LESS REFUND FROM LINE 6	\$		<b>15</b>	
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$		<b>16</b>	

**NOTES:**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Nokomis Golden Manor COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0027961

CONTACT PERSON REGARDING THIS REPORT Linda Peppenhorst

TELEPHONE (618) 327-3064 FAX #: (618) 327-3083

**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>10-000-551-51</u>	<u>10-2-188A-1</u>	\$ <u>40,720.74</u>	\$ <u>40,720.74</u>
2. <u>10-000-188-05</u>	<u>10-2-188A</u>	\$ <u>172.10</u>	\$ <u>172.10</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>40,892.84</u>	\$ <u>40,892.84</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 Nokomis Golden Manor

# 0027961 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 32,807 B. General Construction Type: Exterior Brick Frame Steel & Brick 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).

Section Not Applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>217,800</u>	<u>1983</u>	<u>\$ 10,000</u>	<u>1</u>
2	<u>Home Office</u>		<u>1989</u>	<u>1,201</u>	<u>2</u>
3	<b>TOTALS</b>	<b>217,800</b>		<b>\$ 11,201</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Nokomis Golden Manor

# 0027961

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	54		1970	1970	\$ 466,571	\$ 19,684	26	\$	\$(19,684)	\$ 466,571	4
5	25		1975	1975	205,532		40	5,139	5,139	164,425	5
6	7		1984	1984	45,669		40	1,141	1,141	26,260	6
7	8		1987	1987	104,200	3,872	30	3,473	(399)	69,466	7
8	8		1994	1994	225,527	7,777	40	5,638	(2,139)	72,842	8
	<b>Improvement Type**</b>										
9	Various Improvements		1974		2,187		25			2,187	9
10	Various Improvements		1980		1,617		25			1,617	10
11	Morton Building		1982		22,363		20			22,363	11
12	Frie Doors		1986		2,092		10			2,092	12
13	Smoke Detectors		1986		446		10			446	13
14	Floor Coverings		1986		3,700		10			3,700	14
15	Roof		1986		8,940		10			8,940	15
16	Sprinkler System		1987		11,964		10			11,964	16
17	Boiler Tubs		1987		4,880		10			4,880	17
18	Roof		1988		58,230	1,455	40	1,455		27,295	18
19	Stainless Steel Fire Shutters		1988		4,385	109	40	109		2,019	19
20	15 Ton Air Conditioner		1989		6,500		10			6,500	20
21	Painting & Wallpapering		1986		1,557		10			1,557	21
22	Nurse Station Monitors		1992		3,345		10			3,345	22
23	Nurse Station Counters		1992		7,155	477	15	477		6,718	23
24	Grease Trap		1992		2,425		10			2,425	24
25	3 Ton Air Conditioner		1992		2,600		5			2,600	25
26	Nurse Call Station		1993		22,218	1,481	15	1,481		19,749	26
27	Air Cleaner, Heaters		1993		3,838	255	15	255		3,412	27
28	New Road		1994		3,624		5			3,624	28
29	Kick Plates for Doors		1994		2,785		10			2,785	29
30	Walk in Cooler With Ramp		1996		4,656	311	15	311		3,283	30
31	Three Door Freezer		1996		3,846	257	15	257		2,713	31
32	New Additions - Offices, Activities, Social Services		1996		164,964	6,109	27	6,109		63,644	32
33	Flooring - New Additions		1996		1,368	80	10	80		1,368	33
34	Lighting - New Additions		1996		1,337	89	15	89		928	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Nokomis Golden Manor

# 0027961

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Phone Wiring- New Addition	1996	\$ 1,966	\$ 113	10	\$ 113	\$	\$ 1,966	37
38	Plumbing - New Addition	1996	2,045	103	20	103		1,065	38
39	A/C New Addition	1996	4,304	253	10	253		4,304	39
40	Blacktop Parking Lot	1997	16,000	1,600	10	1,600		15,200	40
41	Kitchen & Outside Drains	1997	5,476	365	15	365		3,346	41
42	Carpet	1998	3,070	306	10	306		2,660	42
43	80 Gallon Water Heater	1998	2,030	136	15	136		1,105	43
44	Flooring Kitchen Tiles	1998	1,877	187	10	187		1,690	44
45	Fire Doors	1998	3,325	333	10	333		2,854	45
46	Sales Tax on New Additions	1998	1,138	113	10	113		958	46
47	Sidewalk	1998	1,965	131	15	131		1,103	47
48	Air Freshener System	1998	2,927	195	15	195		1,691	48
49	Wallpaper	1999	4,943	494	10	494		3,830	49
50	Tile	1999	22,120	2,213	10	2,213		16,222	50
51	Carpet	1999	3,786	378	10	378		2,682	51
52	Ceramic Tile	1999	3,622	362	10	362		2,565	52
53	Wallpaper	1999	9,913		5			9,913	53
54	Carpeting Painting , And Wallpaper	1999	29,338		5			29,338	54
55	Vinyl Flooring anf Installation	2000	17,547	1,754	10	1,754		12,283	55
56	Wallpaper	2000	7,372		5			7,372	56
57	Wall & Door signs	2000	1,310		5			1,310	57
58	New Lighting	2000	968	97	10	97		638	58
59	Window Treatments	2000	2,787		5			2,787	59
60	Baseboard, Chair Rails, Molding	2000	1,352	91	15	91		586	60
61	Carpet	2000	280		5			280	61
62	Doors	2000	624	63	10	63		432	62
63	Replace Main Electrical Breaker	2000	6,730	336	20	336		2,328	63
64	Resurface Parking Lot	2000	1,260	126	10	126		819	64
65	Air Conditioners	2000	5,979	598	10	598		3,837	65
66	Concrete and labor	2000	1,745	117	15	117		707	66
67	Cabinets	2001	28,284	1,415	20	1,415		8,250	67
68	Ceiling Fan	2001	6,720	672	10	672		3,920	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,603,324	\$ 54,507		\$ 38,565	\$ (15,942)	\$ 1,159,759	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Nokomis Golden Manor

# 0027961

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,603,324	\$ 54,507		\$ 38,565	\$ (15,942)	\$ 1,159,759	1
2	Air Conditioner	2001	6,014	602	10	602		3,308	2
3	Fire Doors	2002	13,533	903	15	903		4,361	3
4	Cooing Coil-Kitchen	2002	5,148	514	10	514		2,102	4
5	Flooring Tile	2002	9,692	970	10	970		4,604	5
6	3 Air Handler Units	2003	12,000	800	15	800		3,200	6
7	15 Ton A/C Unit	2003	6,955	695	10	695		2,550	7
8	Door Alarm	2003	13,806	1,380	10	1,380		4,602	8
9	Blinds	2003	2,271	455	5	455		1,401	9
10	Water Heater	2003	6,056	404	15	404		1,380	10
11	Floor Tile & Cove Base	2003	867	87	10	87		275	11
12	Sidewalk/Patio	2003	4,492	299	15	299		898	12
13	Hot Water Cooling coil	2003	1,900	126	15	126		486	13
14	2 A/C Units	2006	3,312	442	5	442		442	14
15	Fire Alarm System	2006	9,133	609	10	609		609	15
16									16
17	Home Office Parking Lot	1989	378		5			378	17
18	Home Office New Building	1995	18,724		25	749	749	8,363	18
19	Home Office Interior Finishes	1996	1,161		15	77	77	813	19
20	Home Office Carpet	1996	406		5			406	20
21	Home Office Cabinets	1996	643		20	32	32	337	21
22	Home Office Electrical	1996	223		15	15	15	156	22
23	Home Office Front Door	2002	306		10	31	31	130	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,720,344	\$ 62,793		\$ 47,755	\$ (15,038)	\$ 1,200,560	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	\$ 125,687	\$ 12,456	\$ 14,080	\$ 1,624	3-15yrs	\$ 73,094	71
72	Current Year Purchases	2,775		240	240		240	72
73	Fully Depreciated Assets	289,009					289,009	73
74								74
75	TOTALS	\$ 417,471	\$ 12,456	\$ 14,320	\$ 1,864		\$ 362,343	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 Business	1998 Ford E350 Van	1998	\$ 24,406	\$	\$	\$	4yrs	\$ 24,406	76
77	Home Office Vehicle	2004 Lexus RX 330	2003	7,925		1,981	1,981	4yrs	6,935	77
78	Home Office Vehicle	2006 Sierra Green Ext Cab	2006	2,848		593	593	4yrs	593	78
79	Home Office Vehicle	2002 Ford F150 P/U - Sold in '06	2002			114	114			79
80	TOTALS			\$ 35,179	\$	\$ 2,688	\$ 2,688		\$ 31,934	80

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,184,195	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,249	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,763	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,486)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,594,837	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	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor

# 0027961

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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?

N/A YES  N/A NO

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

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section Not Applicable</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	\$	8,300	\$ 169,682	\$	8,300	\$ 169,682	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		3,609	103,782		3,609	103,782	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		8,294	168,026		8,294	168,026	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				53,537		53,537	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Lab &amp; X-Ray</u>	39, 3				4,898			4,898	13
14	<b>TOTAL</b>			\$	20,203	\$ 446,388	\$ 53,537	20,203	\$ 499,925	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor# 0027961Report 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 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 161,869	\$	1
2	Cash-Patient Deposits	1,590		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	577,456		3
4	Supply Inventory (priced at <u>cost</u> )	4,069		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Investment in LTC Insurance</u>	18,860		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 763,844	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,645		13
14	Buildings, at Historical Cost	2,058,262		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	324,580		16
17	Accumulated Depreciation (book methods)	(1,600,876)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 807,611	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,571,455	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 148,422	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,590		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,794		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,368		31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Insurance Payable</u>	25,613		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 325,787	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 325,787	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,245,668	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,571,455	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,130,923	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,130,923	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	153,711	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	(38,966)	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)	\$ 114,745	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,245,668	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor# 0027961Report Period Beginning: 01/01/2006Ending: 12/31/2006**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,850,778	1
2	Discounts and Allowances for all Levels	(564,958)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,285,820	3
<b>B. Ancillary Revenue</b>			
4	Day Care	385	4
5	Other Care for Outpatients		5
6	Therapy	620,647	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 621,032	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,523	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 4,523	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,480	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,480	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Diaper Income</u>	335	28
28a	<u>Miscellaneous Income</u>	8,539	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 8,874	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,924,729	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	486,185	31
32	Health Care	1,550,844	32
33	General Administration	509,042	33
<b>B. Capital Expense</b>			
34	Ownership	116,142	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	58,435	35
36	Provider Participation Fee	50,370	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,771,018	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	153,711	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 153,711	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Nokomis Golden Manor

# 0027961

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	1,881	2,227	\$ 54,659	\$ 24.54	1
2	Assistant Director of Nursing	1,670	2,110	38,256	18.13	2
3	Registered Nurses	6,092	6,458	124,233	19.24	3
4	Licensed Practical Nurses	16,230	16,907	265,441	15.70	4
5	CNAs & Orderlies	56,459	57,746	510,867	8.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,779	1,840	17,229	9.36	10
11	Social Service Workers	1,991	2,256	25,860	11.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,105	13,743	100,037	7.28	15
16	Dishwashers					16
17	Maintenance Workers	2,052	2,135	23,684	11.09	17
18	Housekeepers	6,607	6,999	49,731	7.11	18
19	Laundry	6,379	6,663	47,857	7.18	19
20	Administrator	2,102	2,269	67,737	29.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,024	2,208	26,614	12.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,763	1,891	17,246	9.12	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,134	125,452	\$ 1,369,451 *	\$ 10.92	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	153	\$ 7,394	1, 3	35
36	Medical Director	contract	1,625	9, 3	36
37	Medical Records Consultant	20	1,298	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	130	6,436	10, 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	2,341	11, 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	341	\$ 19,094		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	24	796	10, 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	24	\$ 796		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor

# 0027961

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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		
Susan Collman	Administrator	0.0	\$ 21,180	Workers' Compensation Insurance	\$ 84,901	IDPH License Fee	\$ 995		
Jill Spurgeon	Administrator	0	46,557	Unemployment Compensation Insurance	60,380	Advertising: Employee Recruitment	4,165		
				FICA Taxes	103,226	Health Care Worker Background Check			
				Employee Health Insurance	23,088	(Indicate # of checks performed )	1,032		
				Employee Meals		Home Office Dues & Subscriptions	116		
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions	217		
						Other Miscellaneous Dues & Licenses	245		
TOTAL (agree to Schedule V, line 17, col. 1)				Pension Expense	1,155	Franchise Taxes	385		
(List each licensed administrator separately.)			\$ 67,737	Home Office Allocation	8,584				
B. Administrative - Other				Employee Physicals	677	Less: Public Relations Expense	( )		
Description			Amount	Employee Parties	500	Non-allowable advertising	( )		
Section Not Applicable			\$			Yellow page advertising	( )		
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 282,511	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,155		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount	
C. Professional Services				Section Not Applicable			Out-of-State Travel	\$	
Vendor/Payee	Type		Amount						
C.J. Schlosser & Co.	Accounting		\$ 10,590						
Greensfelder, Hemker, & Gale	Legal		7,945				In-State Travel		
							Seminar Expense	1,561	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 18,535				TOTAL	\$ 1,561	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Nokomis Golden Manor

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

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Nokomis Golden Manor

**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? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7.5yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,814 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,370  
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? None
- (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. \$ None Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 46%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? 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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

GOLDEN MANOR NURSING HOME, INC.  
RECLASSIFICATIONS  
12/31/05

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20	1,879
EMPLOYEE BENEFITS	22	500
ADMINISTRATIVE	17	(2,379)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISCELLANEOUS EXPENSE TO THE CORRECT LINES:		
BACKGROUND CHECKS	1,032	
SUBSCRIPTIONS	217	
EMPLOYEE PARTIES	500	
LICENSES & DUES	245	
FRANCHISE TAX	385	
TOTAL	2,379	
HOUSEKEEPING	3	274
LAUNDRY	4	90
CLERICAL	21	41
DIETARY	1	41
NURSING & MEDICAL RECORDS TO RECLASS UNIFORM EXPENSES	10	(446)

GOLDEN MANOR NURSING HOME, INC.  
IDPH ID #0027961  
ATTACHMENT TO SCHEDULE XVII, LINE 28  
12/31/2006

OTHER REVENUE:

VENDING INCOME	\$1,555
LIABILITY INSURANCE DIVIDEND	6,413
MISCELLANEOUS	571
	<u>8,539</u>

GOLDEN MANOR NURSING HOME, INC.  
IDPH ID #0027961  
ATTACHMENT TO SCHEDULE XVII  
12/31/06

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 153,711
DEPRECIATION ADJUSTMENT	31,965
ILLINOIS CORPORATE REPLACEMENT TAXES	461
CONVERSION TO CASH BASIS ADJUSTMENTS	(153,402)
TAX NET INCOME	<u>\$ 32,735</u>