		FOR BHF USE					

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0028787

Facility Name: Taylorville Care Center

Address: 600 South Houston (Number) Taylorville (City) 62568 (Zip Code)

County: Christian

Telephone Number: (217) 824-9636 **Fax #** (217) 824-2472

HFS ID Number:

Date of Initial License for Current Owners: 08/01/1984

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		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 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 Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	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	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,641	1,570	3,089	6,300	8
9	SNF/PED					9
10	ICF	16,620	7,722		24,342	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,261	9,292	3,089	30,642	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.66%

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 08/01/1984

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/1984 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 3,089

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	158,339	16,433	9,973	184,745	855	185,600		185,600			1
2	Food Purchase		153,481		153,481		153,481	(2,545)	150,936			2
3	Housekeeping	84,092	17,243		101,335		101,335	777	102,112			3
4	Laundry	59,811	16,258		76,069		76,069		76,069			4
5	Heat and Other Utilities			114,873	114,873		114,873	(4,292)	110,581			5
6	Maintenance	62,422	67,719	4,800	134,941		134,941	41,968	176,909			6
7	Other (specify):* Sanitation			16,473	16,473		16,473		16,473			7
8	TOTAL General Services	364,664	271,134	146,119	781,917	855	782,772	35,908	818,680			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,345,334	86,174	5,091	1,436,599		1,436,599	(65)	1,436,534			10
10a	Therapy			424,046	424,046		424,046		424,046			10a
11	Activities	47,977	5,018	5,532	58,527	(855)	57,672		57,672			11
12	Social Services	44,435			44,435		44,435		44,435			12
13	CNA Training											13
14	Program Transportation		5,552		5,552		5,552		5,552			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,437,746	96,744	444,269	1,978,759	(855)	1,977,904	(65)	1,977,839			16
	C. General Administration											
17	Administrative	71,451	19,200	670,880	761,531	(6,638)	754,893	(419,798)	335,095			17
18	Directors Fees											18
19	Professional Services			25,159	25,159		25,159	(5,874)	19,285			19
20	Dues, Fees, Subscriptions & Promotions			23,606	23,606	1,775	25,381	(17,054)	8,327			20
21	Clerical & General Office Expenses	22,771	17,865	22,311	62,947	4,863	67,810	39,812	107,622			21
22	Employee Benefits & Payroll Taxes			242,599	242,599		242,599	17,882	260,481			22
23	Inservice Training & Education			14,619	14,619		14,619		14,619			23
24	Travel and Seminar			3,806	3,806		3,806	115	3,921			24
25	Other Admin. Staff Transportation							3,411	3,411			25
26	Insurance-Prop.Liab.Malpractice			42,080	42,080		42,080	7,429	49,509			26
27	Other (specify):*											27
28	TOTAL General Administration	94,222	37,065	1,045,060	1,176,347		1,176,347	(374,077)	802,270			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,896,632	404,943	1,635,448	3,937,023		3,937,023	(338,234)	3,598,789			29

*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 Taylorville Care Center #0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			53,734	53,734		53,734	11,669	65,403			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							46,451	46,451			33
34	Rent-Facility & Grounds			277,800	277,800		277,800	(277,800)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			331,534	331,534		331,534	(219,680)	111,854			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		85,559	17,679	103,238		103,238		103,238			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,317	54,317		54,317		54,317			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		85,559	71,996	157,555		157,555		157,555			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,896,632	490,502	2,038,978	4,426,112		4,426,112	(557,914)	3,868,198			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 Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(278)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,082)	5		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	(2,267)	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				18
19	Entertainment	(1,719)	17		19
20	Contributions	(5,710)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,115)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,004)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,600)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,668)	VAR		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (46,443)		$	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)	(511,471)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (511,471)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (557,914)		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Taylorville Care Center

ID# 0028787

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Lobbying Portion of 2010 IHCA Dues	$ (1,671)	20	1
2	Eliminate Non-Allowable Dues	(729)	17	2
3	Record 2010 IDPH License Paid in 2009	995	20	3
4	Offset Maintenance Reimbursements	(466)	6	4
5	Offset Voided Checks	(18)	17	5
6	Offset Miscellaneous Reimbursements & Refunds	(1,066)	17	6
7	Offset Medical Records Copy Fees	(65)	10	7
8	Straight Line Depr. On Items Req'd To Be Capitalized	352	30	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**	(2,668)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center **#** 0028787 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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	(2,545)	0	0	0	0	0	0	0	0	0	0	(2,545)	2
3	Housekeeping	0	777	0	0	0	0	0	0	0	0	0	777	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,082)	790	0	0	0	0	0	0	0	0	0	(4,292)	5
6	Maintenance	(466)	42,434	0	0	0	0	0	0	0	0	0	41,968	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,093)	44,001	0	0	0	0	0	0	0	0	0	35,908	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	(65)	0	0	0	0	0	0	0	0	0	0	(65)	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	**TOTAL Health Care and Programs**	(65)	0	0	0	0	0	0	0	0	0	0	(65)	16
	C. General Administration													
17	Administrative	(3,532)	92,117	(508,383)	0	0	0	0	0	0	0	0	(419,798)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,115)	5,958	283	0	0	0	0	0	0	0	0	(5,874)	19
20	Fees, Subscriptions & Promotions	(17,390)	296	40	0	0	0	0	0	0	0	0	(17,054)	20
21	Clerical & General Office Expenses	(5,600)	45,412	0	0	0	0	0	0	0	0	0	39,812	21
22	Employee Benefits & Payroll Taxes	0	13,517	4,365	0	0	0	0	0	0	0	0	17,882	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	20	95	0	0	0	0	0	0	0	0	115	24
25	Other Admin. Staff Transportation	0	3,411	0	0	0	0	0	0	0	0	0	3,411	25
26	Insurance-Prop.Liab.Malpractice	0	2,258	5,171	0	0	0	0	0	0	0	0	7,429	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(38,637)	162,989	(498,429)	0	0	0	0	0	0	0	0	(374,077)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(46,795)	206,990	(498,429)	0	0	0	0	0	0	0	0	(338,234)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Taylorville Care Center # 0028787 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	352	11,317	0	0	0	0	0	0	0	0	0	11,669	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	869	45,582	0	0	0	0	0	0	0	0	46,451	33
34	Rent-Facility & Grounds	0	0	(277,800)	0	0	0	0	0	0	0	0	(277,800)	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	**TOTAL Ownership**	352	12,186	(232,218)	0	0	0	0	0	0	0	0	(219,680)	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)**	(46,443)	219,176	(730,647)	0	0	0	0	0	0	0	0	(557,914)	45

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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, Inc.	Mt. Vernon	King Management	Nashville, IL	Home Office
				King Management	Bonita Springs, FL	Management Co.
Jerry & Marilyn King	100.00	Aviston Countryside Manor, Inc.	Aviston	of SW Florida		Management Co.
				Residential Living Ctr	Mt. Vernon, IL	Assisted Living
				Taylorville Estates	Taylorville, IL	Assisted Living
				Trenton Village	Trenton, IL	Assisted Living

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	3	See Schedule VIII	$	King Management Co.	100.00%	$ 777	$ 777	1
2	V	5	See Schedule VIII		King Management Co.	100.00%	790	790	2
3	V	6	See Schedule VIII		King Management Co.	100.00%	42,434	42,434	3
4	V	17	See Schedule VIII		King Management Co.	100.00%	92,117	92,117	4
5	V	19	See Schedule VIII		King Management Co.	100.00%	5,958	5,958	5
6	V	20	See Schedule VIII		King Management Co.	100.00%	296	296	6
7	V	21	See Schedule VIII		King Management Co.	100.00%	45,412	45,412	7
8	V	22	See Schedule VIII		King Management Co.	100.00%	13,517	13,517	8
9	V	24	See Schedule VIII		King Management Co.	100.00%	20	20	9
10	V	25	See Schedule VIII		King Management Co.	100.00%	3,411	3,411	10
11	V	26	See Schedule VIII		King Management Co.	100.00%	2,258	2,258	11
12	V	30	See Schedule VIII		King Management Co.	100.00%	11,317	11,317	12
13	V	33	See Schedule VIII		King Management Co.	100.00%	869	869	13
14	Total			$			$ 219,176	$ * 219,176	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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-Facility & Grounds	$ 277,800	Jerry & Marilyn King	100.00%	$	$ (277,800)	15
16	V	26	Insurance		Jerry & Marilyn King	100.00%	5,171	5,171	16
17	V	30	Depreciation		Jerry & Marilyn King	100.00%			17
18	V	33	Real Estate Taxes		Jerry & Marilyn King	100.00%	45,582	45,582	18
19	V								19
20	V								20
21	V	17	See Schedule VIII	670,880	King Management of SW Florida	100.00%	162,497	(508,383)	21
22	V	19	See Schedule VIII		King Management of SW Florida	100.00%	283	283	22
23	V	20	See Schedule VIII		King Management of SW Florida	100.00%	40	40	23
24	V	22	See Schedule VIII		King Management of SW Florida	100.00%	4,365	4,365	24
25	V	24	See Schedule VIII		King Management of SW Florida	100.00%	95	95	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			$ 948,680			$ 218,033	$ * (730,647)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jerry King	Owner	Mgmt/Consultant	100.00	374,377	13	26.98	Salary	$ 160,879	17, 8	1
2	Denise King	Regional Director	Administrative	0.00	209,505	16	26.98	Salary	90,029	17, 8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00	86,770	13	26.98	Salary	37,287	6, 8	3
4	Marilyn King	Owner	Mgmt/Consultant	100.00	3,766	1	26.98	Salary	1,618	17, 8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 289,813		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 Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	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	3	Housekeeping	Accumulated Costs	13,922,910	6	$ 2,881	$	3,755,232	$ 777	1
2	5	Utilities	Accumulated Costs	13,922,910	6	2,930		3,755,232	790	2
3	6	Maintenance	Accumulated Costs	13,922,910	6	157,328	138,246	3,755,232	42,434	3
4	17	Administrative	Accumulated Costs	13,922,910	6	341,534	333,793	3,755,232	92,117	4
5	19	Professional Fees	Accumulated Costs	13,922,910	6	22,090		3,755,232	5,958	5
6	20	Dues, Fees, & Subscriptions	Accumulated Costs	13,922,910	6	1,097		3,755,232	296	6
7	21	Clerical and Office Expense	Accumulated Costs	13,922,910	6	168,370	149,395	3,755,232	45,412	7
8	22	Employee Benefits	Accumulated Costs	13,922,910	6	50,115		3,755,232	13,517	8
9	24	Travel & Seminars	Accumulated Costs	13,922,910	6	75		3,755,232	20	9
10	25	Other Admin, Staff Transp.	Accumulated Costs	13,922,910	6	12,647		3,755,232	3,411	10
11	26	Insurance	Accumulated Costs	13,922,910	6	8,373		3,755,232	2,258	11
12	30	Depreciation - Other	Accumulated Costs	13,922,910	6	16,852		3,755,232	4,545	12
13	30	Depreciation - Vehicles	Accumulated Costs	13,922,910	6	25,109		3,755,232	6,772	13
14	33	Real Estate Taxes	Accumulated Costs	13,922,910	6	3,221		3,755,232	869	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 812,622	$ 621,434		$ 219,176	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: King Management of SW Florida
Street Address: 3440 Riviera Lakes Ct.
City / State / Zip Code: Bonita Springs, FL 34134
Phone Number: ( )
Fax Number: ( )

	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	17	Administrative	Accumulated Costs	13,922,910	6	$ 602,473	$ 602,473	3,755,232	$ 162,497	1
2	19	Professional Fees	Accumulated Costs	13,922,910	6	1,050		3,755,232	283	2
3	20	Dues, Fees, & Subscriptions	Accumulated Costs	13,922,910	6	150		3,755,232	40	3
4	22	Emplyee Benefits	Accumulated Costs	13,922,910	6	16,185		3,755,232	4,365	4
5	24	Travel & Seminar	Accumulated Costs	13,922,910	6	353		3,755,232	95	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 620,211	$ 602,473		$ 167,280	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 47,400	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.)		$ 46,182	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,218)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 46,800	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.		$ 45,582	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	41,824	8
	2006	43,660	9
	2007	44,205	10
	2008	45,791	11
	2009	46,182	12

Line 4: Accrual based on 2009 taxes paid.

Line 7: Real Estate Tax Expense	**$45,582**
Home Office Allocation	**869**
Total Real Estate Tax	**$46,451**

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Taylorville Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0028787

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-13-28-401-005-00	Cheney Add Lts Thru 6 Blk 3 &	$ 46,182.12	$ 46,182.12
2.		Lts Thru 6 Blk 4 & OL 1 & Vac	$	$
3.		Austin St. & Alley	$	$
4.		282X652 13-28-G	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,182.12	$ 46,182.12

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,610 B. General Construction Type: Exterior Brick Frame Non-Comb Sprinkle 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. [ ] (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).

Taylorville Estates is a 49 unit (27,945 square foot) retirement center which is located on the property adjacent to Taylorville Care Center

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: 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	98 Bed Nursing Home	186,200	1984	$ 40,000	1
2	Home Office Land		1989	1,697	2
3	TOTALS	186,200		$ 41,697	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	98		1984	1974	$ 1,560,000	$	25	$	$	$ 1,560,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	80 Gallon Water Fixture			1985	1,581		10			1,581	9
10	Improvements to Building			1985	12,510	499	25	499		12,510	10
11	Improvements to Parking Lot			1986	1,184		10			1,184	11
12	New Light Fixtures			1987	997		10			997	12
13	Tile Floor			1987	5,941		10			5,941	13
14	Roof			1988	55,100		10			55,100	14
15	Addition to Alarm System			1988	5,610		10			5,610	15
16	Concrete Driveway			1989	2,729		15			2,729	16
17	Nurses' Station			1991	4,809		15			4,809	17
18	Water Heater			1993	3,750		15			3,750	18
19	Air Conditioner			1993	2,800		10			2,800	19
20	New Office			1993	1,500	37	40	37		637	20
21	4 Inch Backflow Preventer			1994	3,966	159	25	159		2,697	21
22	Carpeting			1994	2,471		10			2,471	22
23	Circulating Pump on Water Heater			1994	2,450		14			2,450	23
24	Fence			1995	3,590	100	15	100		3,590	24
25	Water Heater			1995	1,602	9	15	9		1,602	25
26	Sprinkler Heads			1995	1,600	98	15	98		1,600	26
27	New Roof			1996	25,000		10			25,000	27
28	Water Softener			1996	5,908		10			5,908	28
29	Ceramic Tile			1997	5,167		10			5,167	29
30	Garage			1997	7,841		10			7,841	30
31	Rooftop A/C, Ducts and Gas Lines			1997	10,940		10			10,940	31
32	Beauty Shop Addition			1997	6,823	454	15	454		5,913	32
33	Carpeting			1998	4,154		10			4,154	33
34	Windows			1998	5,681		10			5,681	34
35											35
36											36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Heating and A/C Units	1998	$ 4,128	$	5	$	$	$ 4,128	37
38	Air Conditioner Units	1999	25,051		10			25,051	38
39	Rear Parking Lot/Driveway	1999	2,995		10			2,995	39
40	Air Conditioner Units	2000	4,834	322	10	322		4,834	40
41	Landscaping	2001	2,300	230	10	230		2,147	41
42	Electrical	2001	6,725	672	10	672		6,612	42
43	Cabinets	2001	27,445	1,372	20	1,372		13,379	43
44	Water Heater	2001	5,800	386	15	386		3,673	44
45	Wallpaper & Installation	2002	9,016		5			9,016	45
46	Wallguards	2002	5,729	382	15	382		3,342	46
47	Water Heater	2002	6,759	451	15	451		3,718	47
48	Carpet/Baseboard Remodel	2002	16,561	1,656	10	1,656		14,491	48
49	Landscaping	2004	5,106	511	10	511		3,191	49
50	20' Gazebo	2004	24,761	1,651	15	1,651		10,317	50
51	Parking Lot	2004	27,200	3,400	8	3,400		21,250	51
52	Lawn Sprinkler System	2004	3,850	257	15	257		1,626	52
53	Landscaping	2004	8,977	898	10	898		5,536	53
54	Vinyl Fence	2004	5,219	522	10	522		3,175	54
55	Facility Sign	2004	2,632	263	10	263		1,667	55
56	100 Gallon Water Heater	2004	2,390	239	10	239		1,533	56
57	Sidewalk	2004	1,920	128	15	128		811	57
58	Telephone System	2004	4,337	433	10	433		2,638	58
59	Concrete Sidewalk	2005	3,100	207	15	207		1,085	59
60	Storage Building	2006	4,030	201	20	201		823	60
61	Fire System Upgrade	2007	5,577	558	7	797	239	3,121	61
62	Carpet/Baseboard Remodel	2007	31,573	6,315	5	6,315		23,154	62
63	Wallpaper	2007	43,285	8,657	5	8,657		27,414	63
64	Wallpaper	2007	17,086	3,417	5	3,417		10,536	64
65	Rooftop Vents	2007	2,309	231	10	231		924	65
66	Sidewalk	2007	6,785	339	15	452	113	1,356	66
67	Water Softener System	2010	4,700	117	10	117		117	67
68	Tile Flooring	2010	2,244	75	10	75		75	68
69	Plumbing Upgrades	2010	21,525	897	20	897		897	69
70	TOTAL (lines 4 thru 69)		$ 2,091,653	$ 36,143		$ 36,495	$ 352	$ 1,957,294	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	
1	Totals from Page 12A, Carried Forward		$ 2,091,653	$ 36,143		$ 36,495	$ 352	$ 1,957,294	1
2	Ceramic Tile	2010	15,575	65	20	65		65	2
3	Vinyl Tile	2010	1,320		10				3
4	Ceramic Tile	2010	32,565	271	20	271		271	4
5									5
6									6
7									7
8									8
9									9
10									10
11	Home Office Parking Lot	1989	533		10			533	11
12	Home Office Building	1995	26,440		25	1,058	1,058	16,040	12
13	Home Office Interior Finishes Lower Level	1996	1,640		15	109	109	1,585	13
14	Home Office Carpet	1996	573		5			573	14
15	Home Office Cabinets	1996	907		20	45	45	658	15
16	Home Office Electrical	1996	314		15	21	21	304	16
17	Home Office Front Door	2002	432		10	43	43	356	17
18	Home Office Wallpaper	2007	247		5	25	25	78	18
19	Home Office Wallpaper	2008	2,024		5	405	405	1,214	19
20	Home Office Carpet	2008	2,493		5	499	499	1,496	20
21	Home Office Tile	2009	173		10	17	17	35	21
22	Home Office Wallpaper	2009	387		5	77	77	155	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,177,276	$ 36,479		$ 39,130	$ 2,651	$ 1,980,657	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 76,524	$ 5,865	$ 7,401	$ 1,536	5-15 yrs	$ 42,534	71
72	Current Year Purchases	43,476	4,389	5,100	711	3-20 yrs	5,100	72
73	Fully Depreciated Assets	325,313					325,313	73
74								74
75	TOTALS	$ 445,313	$ 10,254	$ 12,501	$ 2,247		$ 372,947	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	2003 Ford Supreme Bus	2003	$ 20,375	$	$	$	4	$ 20,375	76
77	Facility Business	Chevrolet Bus	2007	28,000	7,000	7,000		4	22,750	77
78	Home Office Vehicles	Various	Various	38,367		6,772	6,772	4	22,519	78
79										79
80	TOTALS			$ 86,742	$ 7,000	$ 13,772	$ 6,772		$ 65,644	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)	$	2,751,028	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	53,733	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	65,403	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	11,670	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,419,248	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 Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? N/A ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 ____

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	10,126	$ 193,580	$	10,126	$ 193,580	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		2,462	83,849		2,462	83,849	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		8,322	146,617		8,322	146,617	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				85,559		85,559	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab, X-Ray, Ambul.	39, 3				17,679			17,679	13
14	TOTAL			$	20,910	$ 441,725	$ 85,559	20,910	$ 527,284	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

STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (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	$ 603,989	$	1
2	Cash-Patient Deposits	5,934		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	538,848		3
4	Supply Inventory (priced at Cost)	6,017		4
5	Short-Term Investments			5
6	Prepaid Insurance	(17,509)		6
7	Other Prepaid Expenses	8,339		7
8	Accounts Receivable (owners or related parties)	4,071		8
9	Other(specify): Investment in LTC Insurance	20,090		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,169,779	$	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	508,579		15
16	Equipment, at Historical Cost	447,024		16
17	Accumulated Depreciation (book methods)	(708,407)		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)**	$ 247,196	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,416,975	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 108,131	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,434		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	111,766		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,036		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To Management Company	95,880		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 340,247	$	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)**	$ 340,247	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,076,728	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,416,975	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Taylorville Care Center **#** 0028787 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 866,481	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 866,481	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	231,052	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	(20,805)	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)**	$ 210,247	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)**	$ 1,076,728	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 4,883,468	1
2	Discounts and Allowances for all Levels	(904,986)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,978,482	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	654,491	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 654,491	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	278	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	10,768	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 11,046	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,173	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,173	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	11,956	28
28a	Diapers	16	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,972	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,657,164	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	781,917	31
32	Health Care	1,978,759	32
33	General Administration	1,176,347	33
	B. Capital Expense		
34	Ownership	331,534	34
	C. Ancillary Expense		
35	Special Cost Centers	103,238	35
36	Provider Participation Fee	54,317	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,426,112	40
41	**Income before Income Taxes (line 30 minus line 40)****	231,052	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 231,052	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 Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,605	1,860	$ 55,927	$ 30.07	1
2	Assistant Director of Nursing	1,959	2,461	46,714	18.98	2
3	Registered Nurses	7,030	7,933	160,550	20.24	3
4	Licensed Practical Nurses	23,119	24,989	400,904	16.04	4
5	CNAs & Orderlies	63,601	64,221	661,972	10.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,003	5,227	47,977	9.18	10
11	Social Service Workers	4,237	4,527	44,435	9.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,344	17,565	158,339	9.01	15
16	Dishwashers					16
17	Maintenance Workers	3,078	3,633	62,422	17.18	17
18	Housekeepers	8,745	9,535	84,092	8.82	18
19	Laundry	6,900	7,174	59,811	8.34	19
20	Administrator	2,028	2,190	71,451	32.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,883	2,124	22,771	10.72	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	1,579	1,605	19,267	12.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,111	155,044	$ 1,896,632 *	$ 12.23	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	204	$ 10,041	1, 3	35
36	Medical Director	Contract	9,600	9, 3	36
37	Medical Records Consultant	41	2,862	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,538	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Contract	541	10, 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Contract	(94)	10, 3	43
44	Activity Consultant	77	4,678	11, 3	44
45	Social Service Consultant				45
46	Other(specify) Inservice Consultant	4	245	10, 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	326	$ 29,411		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jill Spurgeon	Administrator	0	$ 17,789
Rhonda Baker	Administrator	0	47,242
Susan Collman		0	5,005
Jennifer Stephens		0	1,415
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 71,451

B. Administrative - Other

Description	Amount
Management Fee	$ 670,880
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 670,880

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accounting	$ 12,805
Greensfelder, Hemker, & Gale	Legal	239
Greensfelder, Hemker, & Gale	Collections (Unallowable)	1,858
Mathis, Marifian, Richter, & Grandy	Collections (Unallowable)	10,257
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 25,159

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,899
Unemployment Compensation Insurance	35,461
FICA Taxes	136,699
Employee Health Insurance	15,648
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	975
Employee Physicals	1,890
Employee Relations	1,027
Home Office Allocation	13,517
Management Company Allocation	4,365
TOTAL (agree to Schedule V, line 22, col.8)	$ 260,481

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

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	1,382
Health Care Worker Background Check (Indicate # of checks performed ____)	365
Patient Background Checks	365
IHCA Dues	3,468
Subscriptions	357
Miscellaneous Dues & Licenses	1,059
Home Office Allocation	296
Management Company Allocation	40
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,327

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,006
Seminar Expense	2,800
Home Office Allocation	20
Management Company Allocation	95
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,921

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/10 Ending: 12/31/10

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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA Dues $3,468**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **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? **3-20 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,609** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **54,317**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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? **Yes** Indicate the amount. $ **278**

(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? **56%**
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**

(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 $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

TAYLORVILLE CARE CENTER, INC.
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII
12/31/2010

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	$ 231,052
DEPRECIATION ADJUSTMENT	(50,304)
TRAVEL & ENTERTAINMENT ADJUSTMENT	859
CONTRIBUTIONS ADJUSTMENT	833
ILLINOIS CORPORATE REPLACEMENT TAXES	5,600
CONVERSION TO CASH BASIS ADJUSTMENTS	182,767
TAX NET INCOME	$ 370,807

TAYLORVILLE CARE CENTER, INC.
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII, LINE 28
12/31/2010

OTHER REVENUE:

VENDING MACHINE INCOME	$	2,033
TOBACCO SETTLEMENT INCOME		7,375
MISCELLANEOUS REFUNDS & REIMBURSEMENTS		1,066
MAINTENANCE REIMBURSEMENTS		466
VOIDED CHECK		18
MEDICAL RECORD COPIES		65
RESIDENT SOCIAL SECURITY INCOME		933
	$	11,956

TAYLORVILLE CARE CENTER
ATTACHMENT TO SCHEDULE XIX, SECTION G
12/31/2010

NAME OF EMPLOYEE ATTENDING SEMINAR	JOB TITLE	DATE	LOCATION	SEMINAR TITLE	SEMINAR SPONSOR	SEMINAR COST	TRAVEL/ LODGING COST
Rhonda Haflinger	Social Services	1/9/2010	Carlyle	SSD Basic Training Course	Outcome Services of IL	153	
Alicia Smith	Social Services	1/9/2010	Carlyle	SSD Basic Training Course	Outcome Services of IL	153	
Jill Spurgeon	Administrator	2/2/2010	Web Seminar	Changes in HIPAA - Privacy & Security Laws	IHCA	75	
Rhonda Baker	Administrator	6/23/2010	Springfield	MDS 3.0 - Getting Started	IHCA	165	
Shawndra Smith	Director of Nursing	6/23/2010	Springfield	MDS 3.0 - Getting Started	IHCA	165	
Nikki Durbin	Medicare Coordinator	6/23/2010	Springfield	MDS 3.0 - Getting Started	IHCA	165	
Erin McGuire	Care Plan Coordinator	6/23/2010	Springfield	MDS 3.0 - Getting Started	IHCA	165	
Susan Collman	Medicare Consultant	6/23/2010	Springfield	MDS 3.0 - Getting Started	IHCA	165	
Alicia Pattarozzi	Activities	9/1/2010	Carlyle	MDS 3.0	Outcome Services of IL	85	4
JoEllyn Forcum	Social Services	9/1/2010	Carlyle	MDS 3.0	Outcome Services of IL	85	4
Rhonda Baker	Administrator	9/28/2010	Web Seminar	Which Way Do We Go?	IHCA	75	
JoEllyn Forcum	Social Services	11/16/2010	Carlyle	SSD Basic Training Course	Outcome Services of IL	81	
Rhonda Baker	Administrator	11/2/10 - 11/3/10	Springfield	INHAA Convention	INHAA	175	
Cathy Brown	Assistant Administrator	11/2/10 - 11/3/10	Springfield	INHAA Convention	INHAA	175	
Rhonda Baker	Administrator	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	56
Shawndra Smith	Director of Nursing	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	56
E. Hogge	R.N. - Restorative Nurse	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	56
JoEllyn Forcum	Social Services	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	56
F. Braden	Medical Records	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	56
Alicia Pattarozzi	Activities	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	56
Linda Childers	Assistant Director of Nursing	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	56
J. Stephens	Assistant Administrator	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	56
K. Walter	Care Plan Coordinator	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	55
C. Johnson	Dietary Manager	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	55
J. Funk	C.N.A.	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	55
B. Spensor	R.N.	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	55
K. Peel	R.N.	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	55
A. Locque	Activities	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	55
Alicia Smith	Social Services	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	55
S. Zepin	C.N.A.	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	55
Nikki Durbin	Medicare Coordinator	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	55
A. Las	C.N.A.	9/13/10 - 9/16/10	Peoria	IHCA Convention	IHCA	44	55
Rhonda Baker	Administrator	6/3/2010	Springfield	Pioneer Meeting	IL Pioneer Coalition	42	
Nikki Durbin	Medicare Coordinator	6/3/2010	Springfield	Pioneer Meeting	IL Pioneer Coalition	42	
Shawndra Smith	Director of Nursing	6/3/2010	Springfield	Pioneer Meeting	IL Pioneer Coalition	42	
						2,800	1,006
							3,806
					Home Office Allocation		20
					Management Company Allocation		95
							3,921

TAYLORVILLE CARE CENTER
IDPH# 0028787
ATTACHMENT TO SCHEDULE V
RECLASSIFICATION
12/31/2010

DESCRIPTION	SCHED V LINE #		INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20		$ 1,775
CLERICAL & GENERAL OFFICE	21		4,863
ADMINISTRATIVE	17		(6,638)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISC. EXPENSE TO THE CORRECT LINES:			
BACKGROUND CHECKS	$	730	
LICENSES & FEES		688	
SUBSCRIPTIONS		357	
MONTHLY BILLING FEES		4,863	
TOTAL	$	6,638	
DIETARY	1		855
ACTIVITIES	11		(855)
TO RECLASS DIETARY CONSULTANT			

Taylorville Care Center, Inc.
IDPH ID # 0028787
Attachment To Schedule VII C
Compensation Paid By Other Nursing Homes
12/31/10

Name	Aviston Countryside Manor	Mt. Vernon Countryside Manor	Total
Jerry King	$ 182,800	$ 191,577	$ 374,377
Denise King	102,296	107,209	209,505
Keith King	42,368	44,402	86,770
Marilyn King	1,839	1,927	3,766
Total Schedule VII C, Col. 5	$ 329,302	$ 345,115	$ 674,418