

		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:** 0028787

**Facility Name:** Taylorville Care Center

**Address:** 600 South Houston Taylorville 62568  
 Number City Zip Code

**County:** Christian

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

**HFS ID Number:** 37-11060662

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

**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.

<b>Officer or Administrator of Provider</b>	(Signed) _____
	(Date) _____
	(Type or Print Name) _____
	(Title) _____
<b>Paid Preparer</b>	(Signed) <u>Compilation Report Attached</u>
	(Date) _____
	(Print Name and Title) <u>Cindy A. Tefteller</u>
	(Firm Name & Address) <u>C.J. Schlosser &amp; Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u>
	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>
	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: 01/01/2006 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>98</u>	Skilled (SNF)	<u>98</u>	<u>35,770</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>98</u>	TOTALS	<u>98</u>	<u>35,770</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>1,610</u>	<u>1,681</u>	<u>3,481</u>	<u>6,772</u>	8
9	SNF/PED					9
10	ICF	<u>16,270</u>	<u>6,802</u>		<u>23,072</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,880</u>	<u>8,483</u>	<u>3,481</u>	<u>29,844</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.43%

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 08/01/1984

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 24 and days of care provided 3,481

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Taylorville Care Center # 0028787 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	130,128	10,204	8,402	148,734		148,734		148,734		1
2	Food Purchase		140,064		140,064		140,064	(2,824)	137,240		2
3	Housekeeping	73,163	19,276		92,439		92,439		92,439		3
4	Laundry	54,632	23,424		78,056		78,056		78,056		4
5	Heat and Other Utilities			94,883	94,883		94,883	882	95,765		5
6	Maintenance	66,221	31,734	2,375	100,330		100,330	32,295	132,625		6
7	Other (specify):* Sanitation			7,796	7,796		7,796		7,796		7
8	<b>TOTAL General Services</b>	<b>324,144</b>	<b>224,702</b>	<b>113,456</b>	<b>662,302</b>		<b>662,302</b>	<b>30,353</b>	<b>692,655</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,291,149	69,606	20,604	1,381,359		1,381,359		1,381,359		10
10a	Therapy			514,883	514,883		514,883		514,883		10a
11	Activities	33,401	2,057	5,062	40,520		40,520		40,520		11
12	Social Services	37,230			37,230		37,230		37,230		12
13	CNA Training										13
14	Program Transportation		2,037		2,037		2,037		2,037		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,361,780</b>	<b>73,700</b>	<b>550,149</b>	<b>1,985,629</b>		<b>1,985,629</b>		<b>1,985,629</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	57,605	8,625	290,000	356,230	(2,875)	353,355	(187,301)	166,054		17
18	Directors Fees										18
19	Professional Services			24,338	24,338		24,338	4,337	28,675		19
20	Dues, Fees, Subscriptions & Promotions			2,660	2,660	2,875	5,535	(1,144)	4,391		20
21	Clerical & General Office Expenses	20,546	22,692	15,649	58,887		58,887	37,591	96,478		21
22	Employee Benefits & Payroll Taxes			297,923	297,923		297,923	11,757	309,680		22
23	Inservice Training & Education			391	391		391		391		23
24	Travel and Seminar			3,262	3,262		3,262	734	3,996		24
25	Other Admin. Staff Transportation			50	50		50	2,447	2,497		25
26	Insurance-Prop.Liab.Malpractice			51,289	51,289		51,289	1,121	52,410		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>78,151</b>	<b>31,317</b>	<b>685,562</b>	<b>795,030</b>		<b>795,030</b>	<b>(130,458)</b>	<b>664,572</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,764,075</b>	<b>329,719</b>	<b>1,349,167</b>	<b>3,442,961</b>		<b>3,442,961</b>	<b>(100,105)</b>	<b>3,342,856</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 Taylorville Care Center

#0028787

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

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			40,132	40,132	40,132	69,938	110,070				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes						44,128	44,128				33
34	Rent-Facility & Grounds			277,800	277,800	277,800	(277,800)					34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			317,932	317,932	317,932	(163,734)	154,198				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		92,189	18,621	110,810	110,810		110,810				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655	53,655		53,655				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		92,189	72,276	164,465	164,465		164,465				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,764,075	421,908	1,739,375	3,925,358	3,925,358	(263,839)	3,661,519				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: 01/01/2006

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	(790)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,034)	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	(3,815)	17		19
20	Contributions				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	(2,298)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,486)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,810)	VAR		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (16,233)		\$	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)	(247,606)	VAR	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (247,606)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (263,839)		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		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Taylorville Care Center

ID# 0028787

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	To record 2006 IDPH license paid in 2005	\$ 995	20	1
2	Eliminate Civic Dues	(374)	17	2
3	Adjust for depr on items req'd to be capitalized for cost rp	519	30	3
4	Offset Liability Insurance Dividend	(5,543)	26	4
5	Offset Copy Reimbursements	(407)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(4,810)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Taylorville Care Center

# 0028787

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	(2,824)	0	0	0	0	0	0	0	0	0	0	(2,824)	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	882	0	0	0	0	0	0	0	0	0	882	5
6	Maintenance	0	32,295	0	0	0	0	0	0	0	0	0	32,295	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,824)</b>	<b>33,177</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>30,353</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	(4,189)	(183,112)	0	0	0	0	0	0	0	0	0	(187,301)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,337	0	0	0	0	0	0	0	0	0	4,337	19
20	Fees, Subscriptions & Promotions	(1,303)	159	0	0	0	0	0	0	0	0	0	(1,144)	20
21	Clerical & General Office Expenses	(2,893)	40,484	0	0	0	0	0	0	0	0	0	37,591	21
22	Employee Benefits & Payroll Taxes	0	11,757	0	0	0	0	0	0	0	0	0	11,757	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	734	0	0	0	0	0	0	0	0	0	734	24
25	Other Admin. Staff Transportation	0	2,447	0	0	0	0	0	0	0	0	0	2,447	25
26	Insurance-Prop.Liab.Malpractice	(5,543)	1,875	4,789	0	0	0	0	0	0	0	0	1,121	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(13,928)</b>	<b>(121,319)</b>	<b>4,789</b>	<b>0</b>	<b>(130,458)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(16,752)</b>	<b>(88,142)</b>	<b>4,789</b>	<b>0</b>	<b>(100,105)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Taylorville Care Center

# 0028787

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	519	7,019	62,400	0	0	0	0	0	0	0	0	69,938	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	804	43,324	0	0	0	0	0	0	0	0	44,128	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	<b>TOTAL Ownership</b>	<b>519</b>	<b>7,823</b>	<b>(172,076)</b>	<b>0</b>	<b>(163,734)</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>(16,233)</b>	<b>(80,319)</b>	<b>(167,287)</b>	<b>0</b>	<b>(263,839)</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, Inc.	Mt. Vernon	King Management	Nashville	Home Office
Jerry & Marilyn King	100.00	Golden Manor Nursing Home, Inc.	Nokomis			
Jerry & Marilyn King	100.00	Aviston Countryside Manor, Inc.	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%	\$ 882	\$ 882
2	V	6 See Schedule VIII		King Management Co.	100.00%	32,295	32,295
3	V	17 See Schedule VIII	290,000	King Management Co.	100.00%	106,888	(183,112)
4	V	19 See Schedule VIII		King Management Co.	100.00%	4,337	4,337
5	V	20 See Schedule VIII		King Management Co.	100.00%	159	159
6	V	21 See Schedule VIII		King Management Co.	100.00%	40,484	40,484
7	V	22 See Schedule VIII		King Management Co.	100.00%	11,757	11,757
8	V	24 See Schedule VIII		King Management Co.	100.00%	734	734
9	V	25 See Schedule VIII		King Management Co.	100.00%	2,447	2,447
10	V	26 See Schedule VIII		King Management Co.	100.00%	1,875	1,875
11	V	30 See Schedule VIII		King Management Co.	100.00%	7,019	7,019
12	V	33 See Schedule VIII		King Management Co.	100.00%	804	804
13	V						
14	Total		\$ 290,000			\$ 209,681	\$ * (80,319)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center# 0028787Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 Rent-Facility & Grounds	\$ 277,800	Jerry & Marilyn King	100.00%	\$	(277,800)	15
16	V	26 Insurance		Jerry & Marilyn King	100.00%	4,789	4,789	16
17	V	30 Depreciation		Jerry & Marilyn King	100.00%	62,400	62,400	17
18	V	33 Real Estate Taxes		Jerry & Marilyn King	100.00%	43,324	43,324	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 277,800			\$ 110,513	\$ * (167,287)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Taylorville Care Center

#

0028787

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	59,967	16	26.16	Salary	\$ 21,246	17,8	1
2	Denise King	Regional Director	Administrative	0.00	230,563	16	26.16	Salary	81,686	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00	61,475	13	26.16	Salary	21,780	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00	223,372	0	N/A	Salary	0	N/A	4
5	Elizabeth King	Dietary	Dietary	0.00	2,448	0	N/A	Salary	0	N/A	5
6	Marilyn King	Owner	Mgmt/Consultant	100.00	2,954	1	26.16	Salary	1,046	17,8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 125,758		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: 01/01/2006

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	\$ 29,831	\$ 882	1
2	6	Maintenance	Patient Days	114,030	4	123,448	29,831	32,295	2
3	17	Administrative	Patient Days	114,030	4	408,584	29,831	106,888	3
4	19	Professional Fees	Patient Days	114,030	4	16,578	29,831	4,337	4
5	20	Dues, Fees, & Subscriptions	Patient Days	114,030	4	609	29,831	159	5
6	21	Clerical and Office Expense	Patient Days	114,030	4	154,752	29,831	40,484	6
7	22	Employee Benefits	Patient Days	114,030	4	44,942	29,831	11,757	7
8	24	Travel & Seminars	Patient Days	114,030	4	2,804	29,831	734	8
9	25	Other Admin Staff Transp.	Patient Days	114,030	4	9,354	29,831	2,447	9
10	26	Insurance	Patient Days	114,030	4	7,167	29,831	1,875	10
11	30	Depreciation-Other	Patient Days	114,030	4	12,760	29,831	3,338	11
12	30	Deprciation-Autos	Patient Days	114,030	4	14,071	29,831	3,681	12
13	33	Real Estate Taxes	Patient Days	114,030	4	3,074	29,831	804	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	\$ 209,681	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>42,000</b>	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.)		2005	\$	<b>41,824</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(176)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>43,500</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>43,324</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2001	<u>35,441</u>	<u>8</u>			
2002	<u>36,902</u>	<u>9</u>			
2003	<u>38,242</u>	<u>10</u>			
2004	<u>40,123</u>	<u>11</u>			
2005	<u>41,824</u>	<u>12</u>			
<b>Line 4: Accrual is based on 2005 taxes paid.</b>		<b>Line 7: Real Estate Tax</b>		<b>43,324</b>	
		<b>Home Office Allocation</b>		<b>804</b>	
		<b>Total Real Estate Tax</b>		<b>44,128</b>	
			<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2005	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

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

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 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 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>17-13-28-401-005</u>	<u>Cheneys Add Lts 1 Thru 6 Blk 3 &amp;</u>	<u>\$ 41,824.22</u>	<u>\$ 41,824.22</u>
2. _____	<u>Lts 1 Thru 6 Blk 4 &amp; Ol 1 &amp; Vac</u>	<u>\$ _____</u>	<u>\$ _____</u>
3. _____	<u>Austin St &amp; Alley</u>	<u>\$ _____</u>	<u>\$ _____</u>
4. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
5. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
6. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
7. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
8. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
9. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
	<b>TOTALS</b>	<u>\$ 41,824.22</u>	<u>\$ 41,824.22</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 Taylorville Care Center

# 0028787 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**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  (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).

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  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>98 Bed Nursing Home</u>	<u>186,200</u>	<u>1984</u>	<u>\$ 40,000</u>	1
2	<u>Home Office Land</u>		<u>1989</u>	<u>1,646</u>	2
3	<b>TOTALS</b>	<b>186,200</b>		<b>\$ 41,646</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Taylorville Care Center

# 0028787

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 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	\$ 62,400	\$ 62,400	\$ 1,404,217	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		80 Gallon Water Fixture		1985	1,581		10			1,581	9
10		Improvements to Building		1985	12,510	501	25	501		10,510	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	24	10		(24)	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		Nurse's Station		1991	4,809		15	106	106	4,809	17
18		Water Heater		1993	3,750	250	15	250		3,458	18
19		Air Conditioner		1993	2,800		10			2,800	19
20		New Office		1993	1,500	38	40	38		488	20
21		4inch Backflow Preventer		1994	3,966	158	25	158		2,062	21
22		Carpeting		1994	2,471		10			2,471	22
23		Circulating Pump on Water Heater		1994	2,450	175	14	175		2,144	23
24		Fence		1995	3,590	239	15	239		2,772	24
25		Water Heater		1995	1,602	107	15	107		1,273	25
26		Sprinkler Heads		1995	1,600	106	15	106		1,182	26
27		New Roof		1996	25,000	1,458	10	1,458		25,000	27
28		Water Softner		1996	5,908	492	10	492		5,087	28
29		Ceramic Tile		1997	5,167	516	10	516		5,124	29
30		Garage		1997	7,841	784	10	784		7,449	30
31		Rooftop A/C, Ducts and Gas Lines		1997	10,940	1,094	10	1,094		10,393	31
32		Beauty Shop Addition		1997	6,823	455	15	455		4,094	32
33		Carpeting		1998	4,154	416	10	416		3,600	33
34		Windows		1998	5,681	569	10	569		4,829	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 Taylorville Care Center

# 0028787

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	Heating and A/C Units	1998	\$ 4,128	\$	5	\$	\$	\$ 4,128	37
38	Air Conditioner Units	1999	25,051	2,505	10	2,505		18,997	38
39	Rear Parking Lot/Driveway	1999	2,995	300	10	300		2,172	39
40	Air Conditioner Units	2000	4,834	483	10	483		3,061	40
41	Landscaping	2001	2,300	230	10	230		1,227	41
42	Electrical	2001	6,725	673	10	673		3,923	42
43	Cabinets	2001	27,445	1,372	20	1,372		7,890	43
44	Water heater	2001	5,800	387	15	387		2,127	44
45	Wallpaper & Installation	2002	9,016	1,803	5	1,803		8,415	45
46	Wallguards	2002	5,729	382	15	382		1,814	46
47	Water heater	2002	6,759	450	15	450		1,915	47
48	Carpet/Baseboard Remodel	2002	16,561	1,656	10	1,656		7,866	48
49	Landscaping	2004	5,106	511	10	511		1,149	49
50	20' Gazebo	2004	24,761	1,651	15	1,651		3,714	50
51	Parking Lot	2004	27,200	3,400	8	3,400		7,650	51
52	Lawn Sprinkler System	2004	3,850	257	15	257		599	52
53	Landscaping	2004	8,977	898	10	898		1,945	53
54	Vinyl Fence	2004	5,219	522	10	522		1,087	54
55	Facility Sign	2004	2,632	263	10	263		614	55
56	100 Gallon Water Heater	2004	2,390	238	10	238		577	56
57	Sidewalk	2004	1,920	128	15	128		299	57
58	Telephone System	2004	4,337	434	10	434		904	58
59	Concrete Sidewalk	2005	3,100	206	20	206		258	59
60	Storage Building	2006	4,030	17	20	17		17	60
61									61
62	Home Office Parking Lot	1989	517		10			517	62
63	Home Office Building	1995	25,645		25	1,026	1,026	11,455	63
64	Home Office Interior Finishes Lower level	1996	1,591		15	106	106	1,113	64
65	Home Office Carpet	1996	556		5			556	65
66	Home Office Cabinets	1996	880		20	44	44	462	66
67	Home Office Electrical	1996	305		15	20	20	213	67
68	Home Office Front Door	2002	419		10	42	42	178	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,986,482	\$ 26,148		\$ 89,868	\$ 63,720	\$ 1,673,746	70

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	\$ 87,692	\$ 8,661	\$ 10,869	\$ 2,208	5-15yrs	\$ 46,151	71
72	Current Year Purchases	8,378	229	558	329	5-10yrs	558	72
73	Fully Depreciated Assets	284,800					284,800	73
74								74
75	TOTALS	\$ 380,870	\$ 8,890	\$ 11,427	\$ 2,537		\$ 331,509	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	1994 Chevy Lumina Van	1995	\$ 13,590	\$	\$	\$	4	\$ 13,590	76
77	Facility Business	2003 Ford Supreme Bus	2003	20,375	5,094	5,094		4	15,706	77
78	Home Office Vehicle	2004 Lexus RX 330	2003	10,855		2,868	2,868	4	9,498	78
79	Home Office Vehicle	2006 Sierra Green Ext Cab	2006	3,901		813	813		813	79
80	TOTALS			\$ 48,721	\$ 5,094	\$ 8,775	\$ 3,681		\$ 39,607	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)	\$ 2,457,719	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 40,132	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 110,070	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 69,938	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,044,862	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: 01/01/2006

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	\$	11,177	\$ 227,176	\$	11,177	\$ 227,176	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		4,477	121,398		4,477	121,398	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		8,199	166,309		8,199	166,309	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				92,189		92,189	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab, X-Ray & Ambul.	39, 3				18,621			18,621	13
14	<b>TOTAL</b>			\$	23,853	\$ 533,504	\$ 92,189	23,853	\$ 625,693	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 Taylorville Care Center# 0028787Report 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	\$ 359,566	\$	1
2	Cash-Patient Deposits	2,214		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	676,433		3
4	Supply Inventory (priced at <u>cost</u> )	5,437		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>	20,090		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,063,740	\$	10
	<b>B. Long-Term Assets</b>			
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	324,035		15
16	Equipment, at Historical Cost	383,247		16
17	Accumulated Depreciation (book methods)	(520,617)		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>	\$ 186,665	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,250,405	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 154,372	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,214		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	136,228		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,942		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Insurance Payable</u>	11,058		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 324,814	\$	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>	\$ 324,814	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 925,591	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,250,405	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 866,084	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 866,084	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	382,618	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	(323,111)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 59,507</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 925,591</b>	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

# 0028787

Report Period Beginning: 01/01/2006

Ending: 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	\$ 4,183,110	1
2	Discounts and Allowances for all Levels	(639,714)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,543,396</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	728,427	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 728,427</b>	<b>8</b>
<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	13,729	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>	<b>\$ 13,729</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	11,668	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 11,668</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous	9,860	28
28a	Diapers	896	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 10,756</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,307,976</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	662,302	31
32	Health Care	1,985,629	32
33	General Administration	795,030	33
<b>B. Capital Expense</b>			
34	Ownership	317,932	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	110,810	35
36	Provider Participation Fee	53,655	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 3,925,358</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>382,618</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 382,618</b>	<b>43</b>

\* 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: 01/01/2006

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	2,122	2,415	\$ 56,787	\$ 23.51	1
2	Assistant Director of Nursing	2,050	2,224	41,008	18.44	2
3	Registered Nurses	6,560	6,914	136,005	19.67	3
4	Licensed Practical Nurses	22,809	23,971	369,576	15.42	4
5	CNAs & Orderlies	65,849	66,504	669,564	10.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,905	4,032	33,401	8.28	10
11	Social Service Workers	3,879	3,936	37,230	9.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,409	16,817	130,128	7.74	15
16	Dishwashers					16
17	Maintenance Workers	4,054	4,520	66,221	14.65	17
18	Housekeepers	8,739	9,445	73,163	7.75	18
19	Laundry	7,491	7,801	54,632	7.00	19
20	Administrator	1,773	2,045	57,605	28.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,939	2,110	20,546	9.74	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	1,653	1,886	18,209	9.65	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,232	154,620	\$ 1,764,075 *	\$ 11.41	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	147	\$ 7,452	1, 3	35
36	Medical Director	52	9,600	9, 3	36
37	Medical Records Consultant	16	1,052	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	386	19,312	10, 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	86	5,062	11, 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	687	\$ 42,478		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	8	240	10, 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8	\$ 240		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

# 0028787

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	
Jaqueline Carpenter	Administrator	0.0	\$ 57,605	Workers' Compensation Insurance	\$ 100,453	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	44,581	Advertising: Employee Recruitment	362	
				FICA Taxes	133,554	Health Care Worker Background Check		
				Employee Health Insurance	14,858	(Indicate # of checks performed )	2,000	
				Employee Meals		Home Office Dues & Subscriptions	159	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	539	
						Other Miscellaneous Dues & Licenses	236	
				Pension Expense	2,839	Franchise Taxes	100	
				Home Office Allocation	11,757			
				Employee Physicals	1,438	Less: Public Relations Expense	( )	
				Employee Parties	200	Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 57,605	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 309,680		\$ 4,391		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fee			\$ 290,000	Section Not Applicable			Out-of-State Travel	\$
							In-State Travel	242
							Seminar Expense	3,754
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 290,000	TOTAL		\$	Entertainment Expense	( )
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)	
C. Professional Services							TOTAL	
Vendor/Payee	Type		Amount				\$ 3,996	
C.J. Schlosser & Co.	Accounting		\$ 10,390					
Greensfelder, Hemker, & Gale	Legal		13,948					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 24,338					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

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

\*\*See instructions.

Facility Name & ID Number Taylorville Care Center

Report Period Beginning: 01/01/2006 Ending:

**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 Taylorville Care Center

**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. \$ 5,394 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. \$ 53,655  
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. \$ 0
- (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? 45%
- 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**

TAYLORVILLE CARE CENTER  
 RECLASSIFICATIONS  
 12/31/06

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20	2,875
ADMINISTRATIVE	17	(2,875)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISCELLANEOUS EXPENSE TO THE CORRECT LINES:		
BACKGROUND CHECKS	\$ 2,000	
MISC LICENSES & FEES	236	
DUES	100	
SUBSCRIPTIONS	439	
FRANCHISE TAX	100	
TOTAL	2,875	

TAYLORVILLE CARE CENTER, INC.  
 IDPH ID #0028787  
 ATTACHMENT TO SCHEDULE XVII  
 12/31/06

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 382,618
DEPRECIATION ADJUSTMENT	27,791
ILLINOIS CORPORATE REPLACEMENT TAXES	2,486
CONVERSION TO CASH BASIS ADJUSTMENTS	(253,356)
TAX NET INCOME	<u>\$ 159,539</u>

TAYLORVILLE CARE CENTER, INC.  
 IDPH ID #0028787  
 ATTACHMENT TO SCHEDULE XVII, LINE 28  
 12/31/2005

OTHER REVENUE:

VENDING INCOME	\$1,644
REFUNDS & REIMBURSEMENTS	790
MISCELLANEOUS	781
CARDINALS TICKETS REIMBURSEMENT	695
LIABILITY INSURANCE DIVIDEND	5,543
REIMBURSEMENT FOR COPIES	407
	<u>9,860</u>

