

Facility Name & ID Number Taylorville Care Center

0028787 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment					
		2 Medicaid Recipient		3 Private Pay	4 Other		5 Total
		8	SNF	1,822	1,156		4,210
9	SNF/PED					9	
10	ICF	15,178	7,999		23,177	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	17,000	9,155	4,210	30,365	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.89%

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 4,210

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	142,472	10,428	7,987	160,887	665	161,552		161,552		1
2	Food Purchase		138,278		138,278		138,278	(1,634)	136,644		2
3	Housekeeping	74,623	18,760		93,383		93,383	680	94,063		3
4	Laundry	58,068	34,294		92,362		92,362		92,362		4
5	Heat and Other Utilities			114,596	114,596		114,596	994	115,590		5
6	Maintenance	55,371	59,453	5,095	119,919		119,919	41,180	161,099		6
7	Other (specify):*			9,409	9,409		9,409		9,409		7
8	TOTAL General Services	330,534	261,213	137,087	728,834	665	729,499	41,220	770,719		8
B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,280,252	57,594	9,752	1,347,598		1,347,598		1,347,598		10
10a	Therapy			636,690	636,690		636,690		636,690		10a
11	Activities	35,957	4,313	5,300	45,570	(665)	44,905		44,905		11
12	Social Services	39,445		68	39,513		39,513		39,513		12
13	CNA Training										13
14	Program Transportation		2,484		2,484		2,484		2,484		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,355,654	64,391	661,410	2,081,455	(665)	2,080,790		2,080,790		16
C. General Administration											
17	Administrative	73,089	26,923	285,000	385,012	(8,464)	376,548	(165,995)	210,553		17
18	Directors Fees										18
19	Professional Services			43,805	43,805		43,805	3,647	47,452		19
20	Dues, Fees, Subscriptions & Promotions			18,304	18,304	3,464	21,768	(14,373)	7,395		20
21	Clerical & General Office Expenses	22,767	16,292	21,957	61,016		61,016	35,897	96,913		21
22	Employee Benefits & Payroll Taxes			312,143	312,143		312,143	16,084	328,227		22
23	Inservice Training & Education			275	275		275		275		23
24	Travel and Seminar			1,080	1,080		1,080	685	1,765		24
25	Other Admin. Staff Transportation			23	23		23	3,349	3,372		25
26	Insurance-Prop.Liab.Malpractice			52,506	52,506	5,000	57,506	7,308	64,814		26
27	Other (specify):*										27
28	TOTAL General Administration	95,856	43,215	735,093	874,164		874,164	(113,398)	760,766		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,782,044	368,819	1,533,590	3,684,453		3,684,453	(72,178)	3,612,275		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: 01/01/207

Ending: 12/31/2007

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			44,960	44,960		44,960	72,340	117,300			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							46,420	46,420			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			322,760	322,760		322,760	(159,040)	163,720			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,925	21,059	128,984		128,984		128,984			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	TOTAL Special Cost Centers		107,925	74,714	182,639		182,639		182,639			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,782,044	476,744	1,931,064	4,189,852		4,189,852	(231,218)	3,958,634			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

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(146)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,488)	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	(3,390)	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	(8,792)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,680)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(19,999)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,495)		\$	30

BHF USE ONLY						
48		49	50	51	52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(190,723)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (190,723)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (231,218)		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	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Taylorville Care Center

ID# 0028787

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Eliminate Civic Dues	\$ (374)	17	1
2	Record depr on items requ'd to be capitalized	479	30	2
3	Eliminate entertainment expenses	(2,754)	21	3
4	Eliminate 2008 IHCA dues paid in 2007	(4,067)	20	4
5	Eliminate 2007 lobbying portion of IHCA dues	(918)	20	5
6	Eliminate penalties	(11,370)	17	6
7	Eliminate 2008 IDPH license fee paid in 2007	(995)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(19,999)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(1,634)	0	0	0	0	0	0	0	0	0	0	(1,634)	2
3	Housekeeping	0	680	0	0	0	0	0	0	0	0	0	680	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	994	0	0	0	0	0	0	0	0	0	994	5
6	Maintenance	0	41,180	0	0	0	0	0	0	0	0	0	41,180	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,634)	42,854	0	0	0	0	0	0	0	0	0	41,220	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(15,134)	(150,861)	0	0	0	0	0	0	0	0	0	(165,995)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,647	0	0	0	0	0	0	0	0	0	3,647	19
20	Fees, Subscriptions & Promotions	(14,772)	399	0	0	0	0	0	0	0	0	0	(14,373)	20
21	Clerical & General Office Expenses	(9,434)	45,331	0	0	0	0	0	0	0	0	0	35,897	21
22	Employee Benefits & Payroll Taxes	0	16,084	0	0	0	0	0	0	0	0	0	16,084	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	685	0	0	0	0	0	0	0	0	0	685	24
25	Other Admin. Staff Transportation	0	3,349	0	0	0	0	0	0	0	0	0	3,349	25
26	Insurance-Prop.Liab.Malpractice	0	2,190	5,118	0	0	0	0	0	0	0	0	7,308	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(39,340)	(79,176)	5,118	0	(113,398)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(40,974)	(36,322)	5,118	0	(72,178)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	479	9,461	62,400	0	0	0	0	0	0	0	0	72,340	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	860	45,560	0	0	0	0	0	0	0	0	46,420	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	479	10,321	(169,840)	0	(159,040)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(40,495)	(26,001)	(164,722)	0	0	0	0	0	0	0	0	(231,218)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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	3 See Schedule VIII	\$	King Management Co.	100.00%	\$ 680	\$ 680 1
2	V	5 See Schedule VIII		King Management Co.	100.00%	994	994 2
3	V	6 See Schedule VIII		King Management Co.	100.00%	41,180	41,180 3
4	V	17 See Schedule VIII	285,000	King Management Co.	100.00%	134,139	(150,861) 4
5	V	19 See Schedule VIII		King Management Co.	100.00%	3,647	3,647 5
6	V	20 See Schedule VIII		King Management Co.	100.00%	399	399 6
7	V	21 See Schedule VIII		King Management Co.	100.00%	45,331	45,331 7
8	V	22 See Schedule VIII		King Management Co.	100.00%	16,084	16,084 8
9	V	24 See Schedule VIII		King Management Co.	100.00%	685	685 9
10	V	25 See Schedule VIII		King Management Co.	100.00%	3,349	3,349 10
11	V	26 See Schedule VIII		King Management Co.	100.00%	2,190	2,190 11
12	V	30 See Schedule VIII		King Management Co.	100.00%	9,461	9,461 12
13	V	33 See Schedule VIII		King Management Co.	100.00%	860	860 13
14	Total		\$ 285,000			\$ 258,999	\$ * (26,001) 14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 Rent-Facility & Grounds	\$ 277,800	Jerry & Marilyn King	100.00%	\$	\$ (277,800)	15
16	V	26 Insurance		Jerry & Marilyn King	100.00%	5,118	5,118	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%	45,560	45,560	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			\$ 113,078	\$ * (164,722)	39

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/207 Ending: 12/31/2007

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	97,185	14	28.55	Salary	\$ 38,832	17,8	1
2	Denise King	Regional Director	Administrative	0.00	227,934	17	28.55	Salary	91,076	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00	62,362	14	28.55	Salary	24,918	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00	211,681	0	N/A	Salary	0	N/A	4
5	Marilyn King	Owner	Mgmt/Consultant	100.00	2,858	1	28.55	Salary	1,142	17,8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 155,968		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: 01/01/207

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	106,310	4	\$ 2,381	\$ 30,351	\$ 680	1
2	5	Utilities	Patient Days	106,310	4	3,483	30,351	994	2
3	6	Maintenance	Patient Days	106,310	4	144,242	87,280	41,180	3
4	17	Administrative	Patient Days	106,310	4	469,846	459,027	134,139	4
5	19	Professional Fees	Patient Days	106,310	4	12,776	30,351	3,647	5
6	20	Dues, Fees, & Subscriptions	Patient Days	106,310	4	1,399	30,351	399	6
7	21	Clerical and Office Expense	Patient Days	106,310	4	158,780	139,605	45,331	7
8	22	Employee Benefits	Patient Days	106,310	4	56,336	30,351	16,084	8
9	24	Travel & Seminars	Patient Days	106,310	4	2,399	30,351	685	9
10	25	Other Admin. Staff Transp.	Patient Days	106,310	4	11,730	30,351	3,349	10
11	26	Insurance	Patient Days	106,310	4	7,671	30,351	2,190	11
12	30	Depreciation- Other	Patient Days	106,310	4	14,162	30,351	4,043	12
13	30	Depreciation- Vehicles	Patient Days	106,310	4	18,979	30,351	5,418	13
14	33	Real Estate Taxes	Patient Days	106,310	4	3,014	30,351	860	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 907,198	\$ 685,912	\$ 258,999	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/207 Ending: 12/31/2007

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
						Original	Balance				
Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	YES	NO									
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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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,

2006 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 Costs

Enter the tax index number and real estate tax assessed for 2006 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 2006

(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 &</u>	<u>\$ 43,660.18</u>	<u>\$ 43,660.18</u>
2. _____	<u>Lts 1 Thru 6 Blk 4 & O1 1 & Vac</u>	<u>\$ _____</u>	<u>\$ _____</u>
3. _____	<u>Austin St. & 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>
TOTALS		<u>\$ 43,660.18</u>	<u>\$ 43,660.18</u>

B. Real Estate Tax Cost Allocation:

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007

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:

01/01/207 Ending: 12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,610 B. General Construction Type: Exterior Brick Frame Non-Comb. Sprinkle Number of Stories 1C. 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 ground (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 CenterF. 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/A3. 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>	<u>1</u>
2	<u>Home Office Land</u>		<u>1989</u>	<u>1,646</u>	<u>2</u>
3	TOTALS	186,200		\$ 41,646	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/207

Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98	1984	1974	\$ 1,560,000	\$	25	\$ 62,400	\$ 62,400	\$ 1,466,617	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	501	25	501		11,011	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	Nurse's Station		1991	4,809		15			4,809	17
18	Water Heater		1993	3,750	250	15	250		3,708	18
19	Air Conditioner		1993	2,800		10			2,800	19
20	New Office		1993	1,500	38	40	38		526	20
21	4 inch Backflow Preventer		1994	3,966	158	25	158		2,220	21
22	Carpeting		1994	2,471		10			2,471	22
23	Circulating Pump on Water Heater		1994	2,450	175	14	175		2,319	23
24	Fence		1995	3,590	239	15	239		3,011	24
25	Water Heater		1995	1,602	107	15	107		1,380	25
26	Sprinkler Heads		1995	1,600	106	15	106		1,288	26
27	New Roof		1996	25,000		10			25,000	27
28	Water Softner		1996	5,908	492	10	492		5,579	28
29	Ceramic Tile		1997	5,167	43	10	43		5,167	29
30	Garage		1997	7,841	392	10	392		7,841	30
31	Rooftop A/C, Ducts and Gas Lines		1997	10,940	547	10	547		10,940	31
32	Beauty Shop Addition		1997	6,823	455	15	455		4,549	32
33	Carpeting		1998	4,154	416	10	416		4,016	33
34	Windows		1998	5,681	569	10	569		5,398	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 & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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		21,502	38	
39	Rear Parking Lot/Driveway	1999	2,995	300	10	300		2,472	39	
40	Air Conditioner Units	2000	4,834	483	10	483		3,544	40	
41	Landscaping	2001	2,300	230	10	230		1,457	41	
42	Electrical	2001	6,725	673	10	673		4,596	42	
43	Cabinets	2001	27,445	1,372	20	1,372		9,262	43	
44	Water Heater	2001	5,800	387	15	387		2,514	44	
45	Wallpaper & Installation	2002	9,016	601	5	601		9,016	45	
46	Wallguards	2002	5,729	382	15	382		2,196	46	
47	Water Heater	2002	6,759	450	15	450		2,365	47	
48	Carpet/Baseboard Remodel	2002	16,561	1,656	10	1,656		9,522	48	
49	Landscaping	2004	5,106	511	10	511		1,660	49	
50	20' Gazebo	2004	24,761	1,651	15	1,651		5,365	50	
51	Parking Lot	2004	27,200	3,400	8	3,400		11,050	51	
52	Lawn Sprinkler System	2004	3,850	257	15	257		856	52	
53	Landscaping	2004	8,977	898	10	898		2,843	53	
54	Vinyl Fence	2004	5,219	522	10	522		1,609	54	
55	Facility Sign	2004	2,632	263	10	263		877	55	
56	100 Gallon Water Heater	2004	2,390	238	10	238		815	56	
57	Sidewalk	2004	1,920	128	15	128		427	57	
58	Telephone System	2004	4,337	434	10	434		1,338	58	
59	Concrete Sidewalk	2005	3,100	206	20	206		464	59	
60	Storage Building	2006	4,030	202	20	202		219	60	
61	Fire System Upgrade	2007	5,577	511	10	730	219	730	61	
62	Carpet	2007	31,573	4,210	5	4,210		4,210	62	
63	Wallpaper	2007	43,285	1,443	5	1,443		1,443	63	
64	Wallpaper	2007	17,086	284	5	284		285	64	
65	Rooftop Vents	2007	2,309	231	10	231		231	65	
66	Sidewalk	2007	6,785		20				66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 2,063,184	\$ 28,916		\$ 91,535	\$ 62,619	\$ 1,750,788	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:

01/01/207

Ending:

12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 2,063,184	\$ 28,916		\$ 91,535	\$ 62,619	\$ 1,750,788		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9	Home Office Parking Lot	1989 564		10			564		9
10	Home Office Building	1995 27,987		25	1,119	1,119	13,620		10
11	Home Office Interior Finishes Lower Level	1996 1,736		15	116	116	1,331		11
12	Home Office Carpet	1996 607		5			607		12
13	Home Office Cabinets	1996 960		20	48	48	552		13
14	Home Office Electrical	1996 333		15	22	22	255		14
15	Home Office Front Door	2002 457		10	46	46	240		15
16	Home Office Wallpaper	2007 261		5	4	4	4		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	TOTAL (lines 1 thru 33)	\$ 2,096,089	\$ 28,916		\$ 92,890	\$ 63,974	\$ 1,767,961		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 94,686	\$ 8,618	\$ 11,496	\$ 2,878	5-10 yrs	\$ 58,329	71
72	Current Year Purchases	10,905	1,007	1,077	70	5-10 yrs	1,077	72
73	Fully Depreciated Assets	285,341					285,341	73
74								74
75	TOTALS	\$ 390,932	\$ 9,625	\$ 12,573	\$ 2,948		\$ 344,747	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	4,669	4,669		4	20,375	77
78	Facility Business	Chevrolet Bus	2007	28,000	1,750	1,750		4	1,750	78
79	Home Office Vehicles	Various	Var	31,846			5,418		4,824	79
80	TOTALS			\$ 93,811	\$ 6,419	\$ 11,837	\$ 5,418		\$ 40,539	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)	\$	2,622,478	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	44,960	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	117,300	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	72,340	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	2,153,247	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.

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

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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ 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	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.

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a,3	hrs	\$	13,369	\$	272,019	\$			13,369	\$	272,019	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		4,324		143,655				4,324		143,655	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a,3	hrs		11,178		221,017				11,178		221,017	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							107,925			107,925	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					21,059						21,059	13
14	TOTAL			\$	28,871	\$	657,750	\$	107,925		28,871	\$	765,675	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

Page 17

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/207

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 351,691	\$	1
2	Cash-Patient Deposits	2,481		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	632,305		3
4	Supply Inventory (priced at Cost)	5,398		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	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,011,965	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	430,650		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	418,601		16
17	Accumulated Depreciation (book methods)	(565,053)		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)	\$ 284,198	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,296,163	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 224,573	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,981		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	161,394		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,066		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	<u>Insurance Payable</u>	59,254		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 481,268	\$	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)	\$ 481,268	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 814,895	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,296,163	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 925,591	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 925,591	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	429,304	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	(540,000)	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)	\$ (110,696)	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)	\$ 814,895	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/207

Ending:

Page 19

12/31/2007

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

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

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,453,743	1
2	Discounts and Allowances for all Levels	(738,918)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,714,825	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	870,772	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 870,772	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,698	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,698	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13,645	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,645	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	5,398	28
28a	<u>Diapers</u>	818	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,216	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,619,156	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	728,834	31
32	Health Care	2,081,455	32
33	General Administration	874,164	33
B. Capital Expense			
34	Ownership	322,760	34
C. Ancillary Expense			
35	Special Cost Centers	128,984	35
36	Provider Participation Fee	53,655	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,189,852	40
41	Income before Income Taxes (line 30 minus line 40)**	429,304	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 429,304	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: 01/01/207

Ending:

12/31/2007

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,755	2,126	\$ 57,916	\$ 27.24	1
2	Assistant Director of Nursing	1,903	2,311	42,311	18.31	2
3	Registered Nurses	6,255	6,956	130,705	18.79	3
4	Licensed Practical Nurses	24,319	26,096	397,981	15.25	4
5	CNAs & Orderlies	62,793	63,027	631,991	10.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,903	4,230	35,957	8.50	10
11	Social Service Workers	3,687	4,103	39,445	9.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,931	17,668	142,472	8.06	15
16	Dishwashers					16
17	Maintenance Workers	3,006	3,385	55,371	16.36	17
18	Housekeepers	8,835	9,499	74,623	7.86	18
19	Laundry	7,278	7,897	58,068	7.35	19
20	Administrator	1,912	2,350	73,089	31.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,963	2,276	22,767	10.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,771	1,937	19,348	9.99	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,311	153,861	\$ 1,782,044 *	\$ 11.58	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	150	\$ 7,702	1,3	35
36	Medical Director	Contract	9,600	9,3	36
37	Medical Records Consultant	25	1,743	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,282	10,3	39
40	Physical Therapy Consultant	Contract	6,727	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	78	4,635	11,8	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	253	\$ 31,689		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	Section N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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		
Jacqueline Carpenter	Administrator	0	\$ 16,006	Workers' Compensation Insurance	\$ 105,349	IDPH License Fee	\$ 995		
Jill Spurgeon	Administrator	0	57,083	Unemployment Compensation Insurance	49,980	Advertising: Employee Recruitment	211		
				FICA Taxes	134,664	Health Care Worker Background Check (Indicate # of checks performed _____)	2,000		
				Employee Health Insurance	16,006	Patient Background Checks			
				Employee Meals		Subscriptions	397		
				Illinois Municipal Retirement Fund (IMRF)*		Franchise Tax	100		
				Pension Expense	3,010	Miscellaneous Dues & Licenses	1,217		
				Home Office Allocation	16,084	Home Office Allocation	399		
				Employee Physicals	2,210	IHCA Dues	2,076		
				Employee Parties	924	Less: Public Relations Expense ()			
						Non-allowable advertising ()			
						Yellow page advertising ()			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,089	TOTAL (agree to Schedule V, line 22, col.8)		\$ 328,227	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 7,395
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			\$ 285,000	Section Not Applicable			Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	1,080	
							Home Office Allocation	685	
							Entertainment Expense ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 285,000	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		\$ 1,765
C. Professional Services									
Vendor/Payee	Type		Amount						
C.J. Schlosser & Co.	Accounting		\$ 9,225						
Greensfelder, Hemker, & Gale	Legal		34,580						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 43,805						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
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 \$2,076
- (3) Did the nursing home make political contributions or payments to a political 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? 7.5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,491 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 benefit: 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? 42%
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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

TAYLORVILLE CARE CENTER
RECLASSIFICATIONS
12/31/07

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20	3,464
INSURANCE - PROP., LIAB., MALPRACTICE	26	5,000
ADMINISTRATIVE	17	(8,464)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISCELLANEOUS EXPENSE TO THE CORRECT LINES:		
BACKGROUND CHECKS	\$ 2,000	
MISC LICENSES & FEES	967	
LIABILITY INSURANCE DEDUCTIBLE	5,000	
SUBSCRIPTIONS	397	
FRANCHISE TAX	100	
TOTAL	8,464	
Dietary	1	665
Activities	2	(665)
To reclass April Dietary consultant recorded in Activities		

TAYLORVILLE CARE CENTER, INC.
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII
12/31/07

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 429,304
DEPRECIATION ADJUSTMENT	(64,584)
GAIN ON DISPOSAL OF ASSETS	1,603
ILLINOIS CORPORATE REPLACEMENT TAXES	6,680
CONVERSION TO CASH BASIS ADJUSTMENTS	74,998
TAX NET INCOME	<u>\$ 448,001</u>

TAYLORVILLE CARE CENTER, INC.
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII, LINE 28
12/31/2007

OTHER REVENUE:

VENDING INCOME	\$1,689
FOOD REBATE	146
MISCELLANEOUS	798
INCOME TAX REFUND	526
COST REPORT SETTLEMENT	1,640
A/R ENTRY	390
IDPA INTEREST	209
	<u>5,398</u>