

Facility Name & ID Number Taylorville Care Center

0028787 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	1,017	1,236	4,497	6,750	8
9	SNF/PED					9
10	ICF	15,245	9,744		24,989	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,262	10,980	4,497	31,739	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.73%

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 4,497

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	147,644	17,789	8,631	174,064		174,064		174,064		1
2	Food Purchase		166,127		166,127		166,127	(2,764)	163,363		2
3	Housekeeping	86,459	20,161		106,620		106,620	879	107,499		3
4	Laundry	62,328	12,589		74,917		74,917		74,917		4
5	Heat and Other Utilities			121,380	121,380		121,380	824	122,204		5
6	Maintenance	56,652	45,524	4,800	106,976		106,976	45,733	152,709		6
7	Other (specify):* Sanitation			13,194	13,194		13,194		13,194		7
8	TOTAL General Services	353,083	262,190	148,005	763,278		763,278	44,672	807,950		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,361,846	78,208	15,245	1,455,299		1,455,299	(1,007)	1,454,292		10
10a	Therapy			867,347	867,347		867,347		867,347		10a
11	Activities	41,618	5,873	4,365	51,856		51,856		51,856		11
12	Social Services	38,556			38,556		38,556		38,556		12
13	CNA Training										13
14	Program Transportation		3,770		3,770		3,770		3,770		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,442,020	87,851	896,557	2,426,428		2,426,428	(1,007)	2,425,421		16
	C. General Administration										
17	Administrative	65,907	17,841	788,069	871,817	(2,987)	868,830	(633,832)	234,998		17
18	Directors Fees										18
19	Professional Services			18,967	18,967		18,967	1,925	20,892		19
20	Dues, Fees, Subscriptions & Promotions			20,350	20,350	2,987	23,337	(15,846)	7,491		20
21	Clerical & General Office Expenses	22,679	17,075	21,718	61,472		61,472	36,433	97,905		21
22	Employee Benefits & Payroll Taxes			250,440	250,440		250,440	14,865	265,305		22
23	Inservice Training & Education			647	647		647	(147)	500		23
24	Travel and Seminar			6,149	6,149		6,149	401	6,550		24
25	Other Admin. Staff Transportation							2,543	2,543		25
26	Insurance-Prop.Liab.Malpractice			47,791	47,791		47,791	7,385	55,176		26
27	Other (specify):*										27
28	TOTAL General Administration	88,586	34,916	1,154,131	1,277,633		1,277,633	(586,273)	691,360		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,883,689	384,957	2,198,693	4,467,339		4,467,339	(542,608)	3,924,731		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:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			49,948	49,948		49,948	47,070	97,018			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							49,392	49,392			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			327,748	327,748		327,748	(181,338)	146,410			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,064	35,753	143,817		143,817		143,817			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		108,064	89,408	197,472		197,472		197,472			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,883,689	493,021	2,615,849	4,992,559		4,992,559	(723,946)	4,268,613			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:

01/01/09

Ending:

12/31/09

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	(761)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,003)	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	(9,554)	17		19
20	Contributions	(4,584)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,994)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,403)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,384)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,683)		\$	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)	(683,263)	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (683,263)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (723,946)		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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Taylorville Care Center

ID# 0028787

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Eliminate Non-Allowable Dues	\$ (649)	17	1
2	Straight Line Depr on Items Req'd to be Capitalized	4,806	30	2
3	Eliminate 2010 IDPH license paid in 2009	(995)	17	3
4	Eliminate Lobbying Expenses	(1,479)	20	4
5	Eliminate Meals and Entertainment	(147)	23	5
6	Eliminate Collection Fees	(3,550)	19	6
7	Offset Voided Check	(363)	17	7
8	Offset Medical Record Copy Fees	(1,007)	10	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	(3,384)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,764)	0	0	0	0	0	0	0	0	0	0	(2,764)	2
3	Housekeeping	0	879	0	0	0	0	0	0	0	0	0	879	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	824	0	0	0	0	0	0	0	0	0	824	5
6	Maintenance	0	45,733	0	0	0	0	0	0	0	0	0	45,733	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,764)	47,436	0	0	0	0	0	0	0	0	0	44,672	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	(1,007)	0	0	0	0	0	0	0	0	0	0	(1,007)	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	(1,007)	0	0	0	0	0	0	0	0	0	0	(1,007)	16
	C. General Administration													
17	Administrative	(11,561)	92,772	(715,043)	0	0	0	0	0	0	0	0	(633,832)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,550)	5,236	239	0	0	0	0	0	0	0	0	1,925	19
20	Fees, Subscriptions & Promotions	(16,057)	169	42	0	0	0	0	0	0	0	0	(15,846)	20
21	Clerical & General Office Expenses	(10,403)	46,836	0	0	0	0	0	0	0	0	0	36,433	21
22	Employee Benefits & Payroll Taxes	0	11,657	3,208	0	0	0	0	0	0	0	0	14,865	22
23	Inservice Training & Education	(147)	0	0	0	0	0	0	0	0	0	0	(147)	23
24	Travel and Seminar	0	332	69	0	0	0	0	0	0	0	0	401	24
25	Other Admin. Staff Transportation	0	2,543	0	0	0	0	0	0	0	0	0	2,543	25
26	Insurance-Prop.Liab.Malpractice	0	2,210	5,175	0	0	0	0	0	0	0	0	7,385	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(41,718)	161,755	(706,310)	0	(586,273)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,489)	209,191	(706,310)	0	(542,608)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Taylorville Care Center# 0028787

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	4,806	11,281	30,983	0	0	0	0	0	0	0	0	47,070	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	901	48,491	0	0	0	0	0	0	0	0	49,392	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	4,806	12,182	(198,326)	0	(181,338)	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)	(40,683)	221,373	(904,636)	0	0	0	0	0	0	0	0	(723,946)	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, IL	Home Office
				King Management	Bonita Springs, FL	Management Co.
Jerry & Marilyn King	100.00	Aviston Countryside Manor, Inc.	Aviston	of SW Florida	Bonita Springs, FL	Management Co.
				Residential Living Ctr	Mt. Vernon, IL	Assisted Living
				Taylorville Estates	Taylorville, IL	Assisted Living
				Trenton Village	Trenton, IL	Assisted Living

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	3 See Schedule VIII	\$	King Management Co.	100.00%	\$ 879	\$ 879	1	
2	V	5 See Schedule VIII		King Management Co.	100.00%	824	824	2	
3	V	6 See Schedule VIII		King Management Co.	100.00%	45,733	45,733	3	
4	V	17 See Schedule VIII		King Management Co.	100.00%	92,772	92,772	4	
5	V	19 See Schedule VIII		King Management Co.	100.00%	5,236	5,236	5	
6	V	20 See Schedule VIII		King Management Co.	100.00%	169	169	6	
7	V	21 See Schedule VIII		King Management Co.	100.00%	46,836	46,836	7	
8	V	22 See Schedule VIII		King Management Co.	100.00%	11,657	11,657	8	
9	V	24 See Schedule VIII		King Management Co.	100.00%	332	332	9	
10	V	25 See Schedule VIII		King Management Co.	100.00%	2,543	2,543	10	
11	V	26 See Schedule VIII		King Management Co.	100.00%	2,210	2,210	11	
12	V	30 See Schedule VIII		King Management Co.	100.00%	11,281	11,281	12	
13	V	33 See Schedule VIII		King Management Co.	100.00%	901	901	13	
14	Total		\$			\$ 221,373	\$ *	221,373	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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)
16	V	26 Insurance		Jerry & Marilyn King	100.00%	5,175	5,175
17	V	30 Depreciation		Jerry & Marilyn King	100.00%	30,983	30,983
18	V	33 Real Estate Taxes		Jerry & Marilyn King	100.00%	48,491	48,491
19	V						
20	V						
21	V	17 See Schedule VIII	788,069	King Management of SW Florida	100.00%	73,026	(715,043)
22	V	19 See Schedule VIII		King Management of SW Florida	100.00%	239	239
23	V	20 See Schedule VIII		King Management of SW Florida	100.00%	42	42
24	V	22 See Schedule VIII		King Management of SW Florida	100.00%	3,208	3,208
25	V	24 See Schedule VIII		King Management of SW Florida	100.00%	69	69
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,065,869			\$ 161,233	\$ * (904,636)

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

Facility Name & ID Number

Taylorville Care Center

0028787

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	156,202	14	28.10	Salary	\$ 71,340	17, 8	1
2	Denise King	Regional Director	Administrative	0.00	196,086	17	28.10	Salary	89,556	17, 8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00	61,749	14	28.10	Salary	28,202	6, 8	3
4	Leslie Pedtke	Administrator	Administrative	0.00	217,591	0	0.00	Salary	0	N/A	4
5	Marilyn King	Owner	Mgmt/Consultant	100.00	3,692	1	28.10	Salary	1,686	17, 8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 190,784		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:

01/01/09

Ending: 12/31/09

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
 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	3	Housekeeping	Accumulated Costs	14,961,763	6	\$ 3,129	\$ 4,204,491	\$ 879	1	
2	5	Utilities	Accumulated Costs	14,961,763	6	2,933	4,204,491	824	2	
3	6	Maintenance	Accumulated Costs	14,961,763	6	162,741	100,357	4,204,491	45,733	3
4	17	Administrative	Accumulated Costs	14,961,763	6	330,130	318,687	4,204,491	92,772	4
5	19	Professional Fees	Accumulated Costs	14,961,763	6	18,634		4,204,491	5,236	5
6	20	Dues, Fees, & Subscriptions	Accumulated Costs	14,961,763	6	602		4,204,491	169	6
7	21	Clerical and Office Expense	Accumulated Costs	14,961,763	6	166,668	146,886	4,204,491	46,836	7
8	22	Employee Benefits	Accumulated Costs	14,961,763	6	41,482		4,204,491	11,657	8
9	24	Travel & Seminars	Accumulated Costs	14,961,763	6	1,182		4,204,491	332	9
10	25	Other Admin. Staff Transp.	Accumulated Costs	14,961,763	6	9,049		4,204,491	2,543	10
11	26	Insurance	Accumulated Costs	14,961,763	6	7,863		4,204,491	2,210	11
12	30	Depreciation - Other	Accumulated Costs	14,961,763	6	15,985		4,204,491	4,492	12
13	30	Depreciation - Vehicles	Accumulated Costs	14,961,763	6	24,159		4,204,491	6,789	13
14	33	Real Estate Taxes	Accumulated Costs	14,961,763	6	3,207		4,204,491	901	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 787,764	\$ 565,930	\$ 221,373		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	17	Administrative	Accumulated Costs	14,961,763	6	\$ 259,866	\$ 4,204,491	\$ 73,026	1
2	19	Professional Fees	Accumulated Costs	14,961,763	6	850	4,204,491	239	2
3	20	Dues, Fees, & Subscriptions	Accumulated Costs	14,961,763	6	150	4,204,491	42	3
4	22	Employee Benefits	Accumulated Costs	14,961,763	6	11,414	4,204,491	3,208	4
5	24	Travel & Seminar	Accumulated Costs	14,961,763	6	245	4,204,491	69	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 272,525	\$ 259,866	\$ 76,584	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Taylorville Care Center

0028787

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/09

Ending:

12/31/09

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:

	1	2	3	4	
A. Land.	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>1,768</u>	<u>2</u>
3	TOTALS	186,200		\$ 41,768	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 30,983	\$ 30,983	\$ 1,560,000	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	80 Gallon Water Fixture		1985	1,581		10			1,581	9
10	Improvements to Building		1985	12,510	500	25	500		12,011	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	Nurses' Station		1991	4,809		15			4,809	17
18	Water Heater		1993	3,750		15			3,750	18
19	Air Conditioner		1993	2,800		10			2,800	19
20	New Office		1993	1,500	37	40	37		600	20
21	4 inch Backflow Preventer		1994	3,966	159	25	159		2,538	21
22	Carpeting		1994	2,471		10			2,471	22
23	Circulating Pump on Water Heater		1994	2,450		14			2,450	23
24	Fence		1995	3,590	239	15	239		3,490	24
25	Water Heater		1995	1,602	107	15	107		1,593	25
26	Sprinkler Heads		1995	1,600	107	15	107		1,502	26
27	New Roof		1996	25,000		10			25,000	27
28	Water Softener		1996	5,908		10			5,908	28
29	Ceramic Tile		1997	5,167		10			5,167	29
30	Garage		1997	7,841		10			7,841	30
31	Rooftop A/C, Ducts and Gas Lines		1997	10,940		10			10,940	31
32	Beauty Shop Addition		1997	6,823	455	15	455		5,459	32
33	Carpeting		1998	4,154		10			4,154	33
34	Windows		1998	5,681		10			5,681	34
35										35
36										36

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

**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:

01/01/09

Ending:

12/31/09

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	1,044	10	1,044		25,051	38
39	Rear Parking Lot/Driveway	1999	2,995	225	10	225		2,996	39
40	Air Conditioner Units	2000	4,834	483	10	483		4,512	40
41	Landscaping	2001	2,300	230	10	230		1,917	41
42	Electrical	2001	6,725	672	10	672		5,940	42
43	Cabinets	2001	27,445	1,372	20	1,372		12,007	43
44	Water Heater	2001	5,800	387	15	387		3,287	44
45	Wallpaper & Installation	2002	9,016		5			9,016	45
46	Wallguards	2002	5,729	382	15	382		2,960	46
47	Water Heater	2002	6,759	451	15	451		3,267	47
48	Carpet/Baseboard Remodel	2002	16,561	1,656	10	1,656		12,835	48
49	Landscaping	2004	5,106	511	10	511		2,680	49
50	20' Gazebo	2004	24,761	1,651	15	1,651		8,666	50
51	Parking Lot	2004	27,200	3,400	8	3,400		17,850	51
52	Lawn Sprinkler System	2004	3,850	257	15	257		1,369	52
53	Landscaping	2004	8,977	898	10	898		4,638	53
54	Vinyl Fence	2004	5,219	522	10	522		2,653	54
55	Facility Sign	2004	2,632	263	10	263		1,404	55
56	100 Gallon Water Heater	2004	2,390	239	10	239		1,294	56
57	Sidewalk	2004	1,920	128	15	128		683	57
58	Telephone System	2004	4,337	433	10	433		2,205	58
59	Concrete Sidewalk	2005	3,100	207	15	207		878	59
60	Storage Building	2006	4,030	201	20	201		622	60
61	Fire System Upgrade	2007	5,577	558	7	797	239	2,324	61
62	Carpet	2007	31,573	6,315	5	6,315		16,839	62
63	Wallpaper	2007	43,285	8,657	5	8,657		18,757	63
64	Wallpaper	2007	17,086	3,417	5	3,417		7,119	64
65	Rooftop Vents	2007	2,309	231	10	231		693	65
66	Sidewalk	2007	6,785	339	15	452	113	904	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,063,184	\$ 36,733		\$ 68,068	\$ 31,335	\$ 1,920,800	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	10
	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	\$ 36,733		\$ 68,068	\$ 31,335	\$ 1,920,800	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11	Home Office Parking Lot	1989	555		10			555	11
12	Home Office Building	1995	27,548		25	1,101	1,101	15,610	12
13	Home Office Interior Finishes Lower Level	1996	1,709		15	114	114	1,538	13
14	Home Office Carpet	1996	597		5			597	14
15	Home Office Cabinets	1996	945		20	47	47	638	15
16	Home Office Electrical	1996	327		15	22	22	295	16
17	Home Office Front Door	2002	450		10	45	45	326	17
18	Home Office Wallpaper	2007	257		5	26	26	56	18
19	Home Office Wallpaper	2008	2,108		5	422	422	843	19
20	Home Office Carpet	2008	2,597		5	520	520	1,039	20
21	Home Office Tile	2009	180		10	18	18	18	21
22	Home Office Wallpaper	2009	403		5	81	81	81	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)		\$ 2,100,860	\$ 36,733		\$ 70,464	\$ 33,731	\$ 1,942,396	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 74,541	\$ 5,916	\$ 12,330	\$ 6,414	5-10 yrs	\$ 43,100	71
72	Current Year Purchases	6,292	299	435	136		435	72
73	Fully Depreciated Assets	322,190					322,190	73
74								74
75	TOTALS	\$ 403,023	\$ 6,215	\$ 12,765	\$ 6,550		\$ 365,725	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	2003 Ford Supreme Bus	2003	\$ 20,375	\$	\$	\$	4	\$ 20,375	76
77	Facility Business	Chevrolet Bus	2007	28,000	7,000	7,000		4	15,750	77
78	Home Office Vehicles	Various	Var	27,156		6,789	6,789	4	16,407	78
79										79
80	TOTALS			\$ 75,531	\$ 7,000	\$ 13,789	\$ 6,789		\$ 52,532	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)	\$ 2,621,182	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,948	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,018	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 47,070	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,360,653	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

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 NO

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

C. Vehicle Rental (See instructions.)

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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.

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)		
TOTAL TRAINED		

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10a, 3	hrs		\$	18,167	\$	366,707	\$		18,167	\$	366,707		1	
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			5,300		219,502			5,300		219,502		2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	10a, 3	hrs			14,853		281,138			14,853		281,138		4	
5	Physician Care		visits												5	
6	Dental Care		visits												6	
7	Work Related Program		hrs												7	
8	Habilitation		hrs												8	
9	Pharmacy	39, 2	# of prescrpts							108,064			108,064		9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Other (specify): _____														12	
13	Other (specify): <u>Lab, X-Ray, Ambul.</u>	39, 3						35,753					35,753		13	
14	TOTAL				\$	38,320	\$	903,100	\$	108,064	38,320	\$	1,011,164		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

0028787

Report Period Beginning: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 174,739	\$	1
2	Cash-Patient Deposits	5,011		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	915,484		3
4	Supply Inventory (priced at <u>Cost</u>)	6,552		4
5	Short-Term Investments			5
6	Prepaid Insurance	11,202		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)	\$ 1,133,078	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	430,650		15
16	Equipment, at Historical Cost	409,763		16
17	Accumulated Depreciation (book methods)	(654,673)		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)	\$ 185,740	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,318,818	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 281,715	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,011		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	133,959		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,652		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 452,337	\$	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)	\$ 452,337	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 866,481	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,318,818	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,005,893	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,005,893	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	597,410	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	(736,822)	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)	\$ (139,412)	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)	\$ 866,481	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,087,199	1
2	Discounts and Allowances for all Levels	(681,700)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,405,499	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,156,682	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,156,682	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	761	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,909	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,670	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,403	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,403	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	4,264	28
28a	Diapers	451	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,715	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,589,969	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	763,278	31
32	Health Care	2,426,428	32
33	General Administration	1,277,633	33
B. Capital Expense			
34	Ownership	327,748	34
C. Ancillary Expense			
35	Special Cost Centers	143,817	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)*	\$ 4,992,559	40
41	Income before Income Taxes (line 30 minus line 40)**	597,410	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 597,410	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:

01/01/09

Ending:

12/31/09

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	1,738	2,106	\$ 58,273	\$ 27.67	1
2	Assistant Director of Nursing	1,976	2,227	43,104	19.36	2
3	Registered Nurses	7,395	8,200	151,931	18.53	3
4	Licensed Practical Nurses	23,473	24,970	398,022	15.94	4
5	CNAs & Orderlies	65,099	66,060	678,918	10.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,493	4,706	41,618	8.84	9
10	Activity Assistants					10
11	Social Service Workers	3,758	4,050	38,556	9.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,160	16,814	147,644	8.78	15
16	Dishwashers					16
17	Maintenance Workers	2,953	3,334	56,652	16.99	17
18	Housekeepers	9,261	7,465	86,459	11.58	18
19	Laundry	7,325	7,661	62,328	8.14	19
20	Administrator	1,940	2,060	65,907	31.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,968	2,188	22,679	10.37	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	1,926	2,183	31,598	14.47	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,465	154,024	\$ 1,883,689 *	\$ 12.23	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	149	\$ 7,681	1, 3	35
36	Medical Director	Contract	9,600	9, 3	36
37	Medical Records Consultant	16	1,118	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	2,617	10, 3	39
40	Physical Therapy Consultant	Contract	11,510	10, 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	72	4,365	11, 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	237	\$ 36,891		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: 01/01/09

Ending: 12/31/09

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	
Jill Spurgeon	Administrator	0.00	65,907	Workers' Compensation Insurance	58,348	IDPH License Fee	995	
				Unemployment Compensation Insurance	31,986	Advertising: Employee Recruitment	70	
				FICA Taxes	142,110	Health Care Worker Background Check (Indicate # of checks performed _____)	1,000	
				Employee Health Insurance	14,769	Patient Background Checks		
				Employee Meals		Subscriptions	228	
				Illinois Municipal Retirement Fund (IMRF)*		Management Company Allocation	42	
				Pension Expense	1,522	Miscellaneous Dues & Licenses	1,327	
				Home Office Allocation	11,657	Home Office Allocation	169	
				Employee Physicals	1,135	IHCA Dues	3,660	
				Employee Relations	570	Less: Public Relations Expense (_____)		
				Management Company Allocation	3,208	Non-allowable advertising (_____)		
						Yellow page advertising (_____)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 65,907	TOTAL (agree to Schedule V, line 22, col.8)		\$ 7,491		
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			\$ 788,069	Section Not Applicable			Out-of-State Travel	\$ _____
							In-State Travel	3,034
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 788,069	TOTAL			Seminar Expense	3,115
C. Professional Services							Home Office Allocation	401
Vendor/Payee	Type		Amount					
C. J. Schlosser & Co.	Accounting		13,050				Entertainment Expense (_____)	
							(agree to Sch. V, line 24, col. 8)	
Greensfelder, Hemker, & Gale	Legal		2,367				TOTAL	\$ 6,550
Mathis, Marifian, Richter, & Grady	Legal - Collections		3,550					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 18,967					

* 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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5-13 Amount of Expense Amortized Per Year								
					6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013	14 FY2014
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 & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/09

Ending:

12/31/09

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 \$3,660
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,916 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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? 55%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

TAYLORVILLE CARE CENTER, INC.
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII
12/31/2009

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 597,410
DEPRECIATION ADJUSTMENT	31,684
TRAVEL & ENTERTAINMENT ADJUSTMENT	4,570
ILLINOIS CORPORATE REPLACEMENT TAXES	10,403
CONVERSION TO CASH BASIS ADJUSTMENTS	46,835
TAX NET INCOME	<u>\$ 690,902</u>

TAYLORVILLE CARE CENTER, INC.
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII, LINE 28
12/31/2009

OTHER REVENUE:

VENDING MACHINE INCOME	\$	1,957
MEDICAL RECORD COPIES		1,007
VOIDED CHECK		363
MISCELLANEOUS		937
	\$	<u>4,264</u>

TAYLORVILLE CARE CENTER
 IDPH# 0028787
 ATTACHMENT TO SCHEDULE V
 RECLASSIFICATION
 12/31/2009

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20	\$ 2,987
ADMINISTRATIVE	17	(2,987)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISC. EXPENSE TO THE CORRECT LINES:		
BACKGROUND CHECKS	\$ 1,000	
MISC DUES & FEES	1,245	
LICENSES	514	
SUBSCRIPTIONS	228	
TOTAL	<u>\$ 2,987</u>	