FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0028787

Facility Name: Taylorville Care Center

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

County: Christian

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2014 to 12/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	442	735	2,366	3,543	8
9	SNF/PED					9
10	ICF	16,547	9,173		25,720	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,989	9,908	2,366	29,263	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.81%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/1984

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 2,366

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	154,192	8,975	8,785	171,952		171,952		171,952			1
2	Food Purchase		158,104		158,104		158,104	(1,600)	156,504			2
3	Housekeeping	125,664	17,150		142,814		142,814	759	143,573			3
4	Laundry	36,014	10,807		46,821		46,821		46,821			4
5	Heat and Other Utilities			98,326	98,326		98,326	(5,218)	93,108			5
6	Maintenance	69,725	58,602	6,833	135,160		135,160	304	135,464			6
7	Other (specify):* Sanitation			10,437	10,437		10,437		10,437			7
8	TOTAL General Services	385,595	253,638	124,381	763,614		763,614	(5,755)	757,859			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,424,630	84,652	5,924	1,515,206		1,515,206		1,515,206			10
10a	Therapy											10a
11	Activities	36,490	3,089	5,028	44,607		44,607		44,607			11
12	Social Services	40,925			40,925		40,925		40,925			12
13	CNA Training											13
14	Program Transportation		7,310		7,310		7,310		7,310			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,502,045	95,051	20,552	1,617,648		1,617,648		1,617,648			16
	C. General Administration											
17	Administrative	93,167	8,979	253,486	355,632	(2,311)	353,321	(130,616)	222,705			17
18	Directors Fees											18
19	Professional Services			24,499	24,499		24,499	(7,089)	17,410			19
20	Dues, Fees, Subscriptions & Promotions			22,624	22,624	2,311	24,935	(13,519)	11,416			20
21	Clerical & General Office Expenses	23,828	14,115	95,279	133,222		133,222	59,218	192,440			21
22	Employee Benefits & Payroll Taxes			287,965	287,965		287,965	10,053	298,018			22
23	Inservice Training & Education			1,749	1,749		1,749		1,749			23
24	Travel and Seminar			4,338	4,338		4,338	1,395	5,733			24
25	Other Admin. Staff Transportation			168	168		168	757	925			25
26	Insurance-Prop.Liab.Malpractice			69,118	69,118		69,118	1,256	70,374			26
27	Other (specify):*											27
28	TOTAL General Administration	116,995	23,094	759,226	899,315		899,315	(78,545)	820,770			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,004,635	371,783	904,159	3,280,577		3,280,577	(84,300)	3,196,277			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

TAYLORVILLE CARE CENTER
IDPH# 0028787
ATTACHMENT TO SCHEDULE V
RECLASSIFICATION
12/31/2014

DESCRIPTION	SCHED V LINE #		INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20		$ 2,311
ADMINISTRATIVE	17		(2,311)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISC. EXPENSE TO THE CORRECT LINES:			
BACKGROUND CHECKS		$ 455	
LICENSES & FEES		1,856	
TOTAL		$ 2,311	

Facility Name & ID Number Taylorville Care Center #0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			68,959	68,959		68,959	8,986	77,945			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			48,053	48,053		48,053	902	48,955			33
34	Rent-Facility & Grounds			50	50		50		50			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			117,062	117,062		117,062	9,888	126,950			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		97,729	288,980	386,709		386,709		386,709			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			213,978	213,978		213,978		213,978			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		97,729	502,958	600,687		600,687		600,687			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,004,635	469,512	1,524,179	3,998,326		3,998,326	(74,412)	3,923,914			45

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(276)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,883)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,324)	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				19
20	Contributions	(103)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,114)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,751)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,194)	VAR		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (31,645)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(42,767)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (42,767)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (74,412)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Taylorville Care Center

ID# 0028787

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adj depreciation for cost report	$ (379)	30	1
2	Eliminate lobbying portion of 2012 IHCA Dues	(1,696)	20	2
3	Offset voided check	(750)	20	3
4	Eliminate Chamber of Commerce Dues	(379)	20	4
5	Eliminate 2015 License paidin 2014	(1,990)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,194)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center # 0028787 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(1,600)	0	0	0	0	0	0	0	0	0	0	(1,600)	2
3	Housekeeping	0	759	0	0	0	0	0	0	0	0	0	759	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,883)	665	0	0	0	0	0	0	0	0	0	(5,218)	5
6	Maintenance	0	304	0	0	0	0	0	0	0	0	0	304	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,483)	1,728	0	0	0	0	0	0	0	0	0	(5,755)	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	0	(114,974)	(15,642)	0	0	0	0	0	0	0	0	(130,616)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,114)	3,025	0	0	0	0	0	0	0	0	0	(7,089)	19
20	Fees, Subscriptions & Promotions	(13,669)	150	0	0	0	0	0	0	0	0	0	(13,519)	20
21	Clerical & General Office Expenses	0	59,218	0	0	0	0	0	0	0	0	0	59,218	21
22	Employee Benefits & Payroll Taxes	0	7,377	2,676	0	0	0	0	0	0	0	0	10,053	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,395	0	0	0	0	0	0	0	0	0	1,395	24
25	Other Admin. Staff Transportation	0	757	0	0	0	0	0	0	0	0	0	757	25
26	Insurance-Prop.Liab.Malpractice	0	1,256	0	0	0	0	0	0	0	0	0	1,256	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(23,783)	(41,796)	(12,966)	0	0	0	0	0	0	0	0	(78,545)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,266)	(40,068)	(12,966)	0	0	0	0	0	0	0	0	(84,300)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Taylorville Care Center # 0028787 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(379)	9,365	0	0	0	0	0	0	0	0	0	8,986	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	902	0	0	0	0	0	0	0	0	0	902	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(379)	10,267	0	0	0	0	0	0	0	0	0	9,888	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(31,645)	(29,801)	(12,966)	0	0	0	0	0	0	0	0	(74,412)	45

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Denise King 2012 Exempt Trust	20	Mt. Vernon Countryside Manor, Inc.	Mt. Vernon	King Management Co.	Nashville, IL	Home Office
Leslie Pedtke 2012 Exempt Trust	20	Aviston Countryside Manor, Inc.	Aviston	King Management	Bonita Springs, FL	Management Co.
Keith King 2012 Exempt Trust	20			of SW Florida		
Elizabeth Todorov 2012 Exempt Trust	20			Residential Living Ctr	Mt. Vernon	Assisted Living
Michelle Hirschfeld 2012 Exempt Trust	20			Taylorville Estates	Taylorville	Assisted Living
				Trenton Village	Trenton	Assisted Living

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	See Schedule VIII	$	King Management Company	0.00%	$ 759	$ 759	1
2	V	5	See Schedule VIII		King Management Company	0.00%	665	665	2
3	V	6	See Schedule VIII		King Management Company	0.00%	304	304	3
4	V	17	See Schedule VIII	196,212	King Management Company	0.00%	81,238	(114,974)	4
5	V	19	See Schedule VIII		King Management Company	0.00%	3,025	3,025	5
6	V	20	See Schedule VIII		King Management Company	0.00%	150	150	6
7	V	21	See Schedule VIII		King Management Company	0.00%	59,218	59,218	7
8	V	22	See Schedule VIII		King Management Company	0.00%	7,377	7,377	8
9	V	24	See Schedule VIII		King Management Company	0.00%	1,395	1,395	9
10	V	25	See Schedule VIII		King Management Company	0.00%	757	757	10
11	V	26	See Schedule VIII		King Management Company	0.00%	1,256	1,256	11
12	V	30	See Schedule VIII		King Management Company	0.00%	9,365	9,365	12
13	V	33	See Schedule VIII		King Management Company	0.00%	902	902	13
14	Total			$ 196,212			$ 166,411	$ * (29,801)	14

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	See Schedule VIII	$ 57,274	King Management of SW Florida	0.00%	$ 41,632	$ (15,642)	15
16	V	22	See Schedule VIII		King Management of SW Florida	0.00%	2,676	2,676	16
17	V								17
18	V								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			$ 57,274			$ 44,308	$ * (12,966)	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: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jerry King	Mgt. Co. Owner	Mgmt/Consultant	0.00	94,905	13	26.69	Salary	$ 40,031	17,8	1
2	Denise King	President	Administrative	0.00	191,329	16	26.69	Salary	80,702	17,8	2
3	Marilyn King	Mgt. Co. Owner	Mgmt/Consultant	0.00	3,796	1	26.69	Salary	1,601	17.8	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 122,334		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

Taylorville Care Center, Inc.
IDPH ID # 0028787
Attachment To Schedule VII C
Compensation Paid By Other Nursing Homes
12/31/14

Name	Aviston Countryside Manor	Mt. Vernon Countryside Manor	Total Sch. VII C Column 5
Jerry King	$ 48,443	$ 46,462	$ 94,905
Denise King	97,662	93,667	191,329
Keith King	-	-	-
Marilyn King	1,938	1,858	3,796
Total	$ 148,043	$ 141,987	$ 290,030

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Accumulated Costs	14,032,388	6	$ 2,844	$	3,744,840	$ 759	1
2	5	Utilities	Accumulated Costs	14,032,388	6	2,491		3,744,840	665	2
3	6	Maintenance	Accumulated Costs	14,032,388	6	1,139		3,744,840	304	3
4	17	Administrative	Accumulated Costs	14,032,388	6	304,409	302,400	3,744,840	81,238	4
5	19	Professional Fees	Accumulated Costs	14,032,388	6	11,335		3,744,840	3,025	5
6	20	Dues, Fees & Subscriptions	Accumulated Costs	14,032,388	6	562		3,744,840	150	6
7	21	Clerical & Office Expense	Accumulated Costs	14,032,388	6	221,899	170,011	3,744,840	59,218	7
8	22	Emp Benefits & Payroll Taxes	Accumulated Costs	14,032,388	6	27,642		3,744,840	7,377	8
9	24	Travel & Seminar	Accumulated Costs	14,032,388	6	5,228		3,744,840	1,395	9
10	25	Other Administrative Transp.	Accumulated Costs	14,032,388	6	2,836		3,744,840	757	10
11	26	Insurance	Accumulated Costs	14,032,388	6	4,707		3,744,840	1,256	11
12	30	Depreciation	Accumulated Costs	14,032,388	6	35,091		3,744,840	9,365	12
13	33	Real Estate Taxes	Accumulated Costs	14,032,388	6	3,379		3,744,840	902	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					$ 623,562	$ 472,411		$ 166,411	25

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Costs	14,032,388	6	$ 156,000	$ 156,000	3,744,840	$ 41,632	1
2	22	Payroll Taxes	Accumulated Costs	14,032,388	6	10,027		3,744,840	2,676	2
3										3
4										4
5										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					$ 166,027	$ 156,000		$ 44,308	25

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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.)**

**** 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: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 47,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 47,853	2
3. Under or (over) accrual (line 2 minus line 1).		$ 53	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 48,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 48,053	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009	46,182	8
2010	46,894	9
2011	46,993	10
2012	47,277	11
2013	47,853	12

Line 4: Accrual based on 2013 actual taxes plus COLA adj.

Line 7: Real estate tax espense:	48,053
Home Office Allocation:	902
Total Expenses Sch. V, Ln 33	48,955

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Taylorville Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0028787

CONTACT PERSON REGARDING THIS REPORT Linda Peppenhorst

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-13-28-401-005-00	Cheneys Add Lts 1 Thru 6 Blk 3	$ 47,852.76	$ 47,852.76
2.		& Lts 1 Thru 6 Blk 4 & OL 1 &	$	$
3.		Vac Austin St. & Alley	$	$
4.		282X652 13-28-G	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47,852.76	$ 47,852.76

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	98 Bed Nursing Home	186,200	1984	$ 40,000	1
2	Home Office Land		1989	1,679	2
3	TOTALS	186,200		$ 41,679	3

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1984	1974	$ 1,560,000	$	25	$	$	$ 1,560,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	80 Gallon Water Fixture			1985	1,581		10			1,581	9
10	Improvements to Building			1985	12,510		25			12,510	10
11	Improvements to Parking Lot			1986	1,184		10			1,184	11
12	New Light Fixtures			1987	997		10			997	12
13	Tile Floor			1987	5,941		10			5,941	13
14	Roof			1988	55,100		10			55,100	14
15	Addition to Alarm System			1988	5,610		10			5,610	15
16	Concrete Driveway			1989	2,729		15			2,729	16
17	Nurses' Station			1991	4,809		15			4,809	17
18	Water Heater			1993	3,750		15			3,750	18
19	Air Conditioner			1993	2,800		10			2,800	19
20	New Office			1993	1,500	37	40	37		787	20
21	4 Inch Backflow Preventer			1994	3,966	159	25	159		3,331	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		15			3,590	24
25	Water Heater			1995	1,602		15			1,602	25
26	Sprinkler Heads			1995	1,600		15			1,600	26
27	New Roof			1996	25,000		10			25,000	27
28	Water Softener			1996	5,908		10			5,908	28
29	Ceramic Tile			1997	5,167		10			5,167	29
30	Garage			1997	7,841		10			7,841	30
31	Rooftop A/C, Ducts and Gas Lines			1997	10,940		10			10,940	31
32	Beauty Shop Addition			1997	6,823		15			6,823	32
33	Carpeting			1998	4,154		10			4,154	33
34	Windows			1998	5,681		10			5,681	34
35	Heating and A/C Units			1998	4,128		5			4,128	35
36	Air Conditioner Units			1999	25,051		10			25,051	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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Rear Parking Lot/Driveway	1999	$ 2,995	$	10	$	$	$ 2,995	37
38	Air Conditioner Units	2000	4,834		10			4,834	38
39	Landscaping	2001	2,300		10			2,300	39
40	Electrical	2001	6,725		10			6,725	40
41	Cabinets	2001	27,445	1,372	20	1,372		18,868	41
42	Water Heater	2001	5,800	387	15	387		5,220	42
43	Wallpaper & Installation	2002	9,016		5			9,016	43
44	Wallguards	2002	5,729	382	15	382		4,870	44
45	Water Heater	2002	6,759	451	15	451		5,520	45
46	Carpet/Baseboard Remodel	2002	16,561		10			16,561	46
47	Landscaping	2004	5,106	383	10	383		5,106	47
48	20' Gazebo	2004	24,761	1,651	15	1,651		16,920	48
49	Parking Lot	2004	27,200		8			27,200	49
50	Lawn Sprinkler System	2004	3,850	257	15	257		2,652	50
51	Landscaping	2004	8,977	748	10	748		8,977	51
52	Vinyl Fence	2004	5,219	478	10	478		5,219	52
53	Facility Sign	2004	2,632	175	10	175		2,632	53
54	100 Gallon Water Heater	2004	2,390	139	10	139		2,390	54
55	Sidewalk	2004	1,920	128	15	128		1,323	55
56	Telephone System	2004	4,337	398	10	398		4,337	56
57	Concrete Sidewalk	2005	3,100	207	15	207		1,912	57
58	Storage Building	2006	4,030	202	20	202		1,629	58
59	Fire System Upgrade	2007	5,577	558	7	66	(492)	5,577	59
60	Carpet/Baseboard Remodel	2007	31,573		5			31,573	60
61	Wallpaper	2007	43,285		5			43,285	61
62	Wallpaper	2007	17,086		5			17,086	62
63	Rooftop Vents	2007	2,309	231	10	231		1,848	63
64	Sidewalk	2007	6,785	338	15	452	114	3,166	64
65	Water Softener System	2010	4,700	470	10	470		1,998	65
66	Tile Flooring	2010	2,244	224	10	224		972	66
67	Plumbing Upgrades	2010	21,525	1,076	20	1,076		5,202	67
68	Ceramic Tile	2010	15,575	779	20	779		3,180	68
69	Vinyl Tile	2010	1,320	132	10	132		528	69
70	TOTAL (lines 4 thru 69)		$ 2,108,548	$ 11,362		$ 10,984	$ (378)	$ 2,045,156	70

**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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,108,548	$ 11,362		$ 10,984	$ (378)	$ 2,045,156	1
2	Ceramic Tile	2010	32,565	1,628	20	1,628		6,784	2
3	Light Fixtures	2011	2,422	242	10	242		848	3
4	Cabinetry & Built-In Desk for Therapy	2011	5,898	393	15	393		1,409	4
5	Roof	2011	50,303	3,353	15	3,353		11,458	5
6	Cherry Flooring	2011	14,258	1,426	10	1,426		4,634	6
7	Shower Room Tile	2011	3,477	232	15	232		792	7
8	Flat Roof	2011	11,269	1,127	10	1,127		3,756	8
9	Roof & Parapet Wall	2011	51,757	3,450	15	3,450		10,351	9
10	Wallpaper and Border	2011	8,393	1,679	5	1,679		5,176	10
11	Tile Flooring Installation	2011	10,000	1,000	10	1,000		3,083	11
12	Custom Nurses' Station	2011	27,690	1,846	15	1,846		5,692	12
13	Hand Rail & Crash Rail	2011	8,946	596	15	596		1,839	13
14	Water Heater	2012	4,114	411	10	411		1,200	14
15	Walk-In Cooler Condensing Unit	2012	2,774	185	15	185		447	15
16	Building Generator	2013	51,847	2,592	20	2,592		3,024	16
17	Gazebo	2013	1,257	84	15	84		112	17
18	Concrete Drive	2013	12,954	864	15	864		1,367	18
19	Concrete Dumpster Pad & Walk	2013	3,700	247	15	247		329	19
20	Cabinets & Countertop	2013	3,010	201	15	201		201	20
21	Rooftop A/C System - 5-ton	2013	5,288	529	10	529		529	21
22	Paint Ceilings in A & C	2014	11,643	2,135	5	2,135		2,135	22
23	Paint Ceilings in Main Hallway	2014	2,800	467	5	467		467	23
24	Maint Ceilings 15 Rooms	2014	9,000	750	5	750		750	24
25	Hallway Lighting	2014	2,080	156	10	156		156	25
26	Fitness Room Lighting	2014	2,430	162	10	162		162	26
27	5-Ton Roof-Top HVAC	2014	5,352	30	15	30		30	27
28	Cable Wiring A Hall	2014	2,600	59	18	59		59	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,456,375	$ 37,206		$ 36,828	$ (378)	$ 2,111,946	34

**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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,456,375	$ 37,206		$ 36,828	$ (378)	$ 2,111,946	1
2	Home Office Parking Lot	1989	527		5			527	2
3	Home Office Building	1995	26,161		25	1,048	1,048	20,057	3
4	Home Office Interior Finishes Lower Level	1996	1,623		15			1,623	4
5	Home Office Carpet	1996	567		5			567	5
6	Home Office Cabinets	1996	898		20	45	45	831	6
7	Home Office Electrical	1996	311		15			311	7
8	Home Office Front Door	2002	427		10			427	8
9	Home Office Wallpaper	2007	244		10	24	24	175	9
10	Home Office Wallpaper	2008	2,002		5			2,002	10
11	Home Office Carpet	2008	2,467		5			2,467	11
12	Home Office Tile	2009	171		10	17	17	102	12
13	Home Office Wallpaper	2009	383		5			383	13
14	Home Office Air Conditioner	2013	600		5	60	60	80	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	TOTAL (lines 1 thru 33)		$ 2,492,756	$ 37,206		$ 38,022	$ 816	$ 2,141,498	34

**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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 242,303	$ 27,340	$ 29,848	$ 2,508	3-20 years	$ 110,560	71
72	Current Year Purchases	72,801	4,413	4,413		3-10 years	4,413	72
73	Fully Depreciated Assets	293,740					293,740	73
74								74
75	TOTALS	$ 608,844	$ 31,753	$ 34,261	$ 2,508		$ 408,713	75

D. Vehicle Costs. (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	Chevrolet Bus	2007	$ 28,000	$	$	$	4	$ 28,000	76
77	Home Office Vehicles	Various	Various	22,796		5,662	5,662	4	6,931	77
78										78
79										79
80	TOTALS			$ 50,796	$	$ 5,662	$ 5,662		$ 34,931	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)	$ 3,194,075	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,959	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 77,945	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,986	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,585,142	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 N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	$	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.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 ☒ N/A NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☒ N/A YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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				97,729		97,729	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Therapy	39,3				271,495			271,495	12
13	Other (specify): Labs,X-ray,Ambul.	39,3				17,485			17,485	13
14	TOTAL			$		$ 288,980	$ 97,729		$ 386,709	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.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 512,665	$	1
2	Cash-Patient Deposits	9,294		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,384,561		3
4	Supply Inventory (priced at Cost)	6,396		4
5	Short-Term Investments			5
6	Prepaid Insurance	43,364		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Investment in LTC Insurance	20,090		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,976,370	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	823,842		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	606,412		16
17	Accumulated Depreciation (book methods)	(892,736)		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)**	$ 537,518	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,513,888	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 92,689	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,294		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	141,885		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,520		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Management Company	36,166		36
37	Provider Assessment	27,437		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 384,991	$	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)**	$ 384,991	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,128,897	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,513,888	$	48

*(See instructions.)

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,852,049	1	
2	Restatements (describe):		2	
3	**Provider Taxes**	(36,267)	3	
4	**Accounts Receivable**	(16,241)	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,799,541	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	907,306	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	(577,950)	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)**	$ 329,356	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)**	$ 2,128,897	24	*

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,067,169	1
2	Discounts and Allowances for all Levels	(748,368)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,318,801	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	570,139	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 570,139	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	276	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	8,513	19
20	Radiology and X-Ray	1,322	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 10,111	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,185	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,185	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	3,226	28
28a	Vending Machine Income	1,170	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,396	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,905,632	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	763,614	31
32	Health Care	1,617,648	32
33	General Administration	899,315	33
	B. Capital Expense		
34	Ownership	117,062	34
	C. Ancillary Expense		
35	Special Cost Centers	386,709	35
36	Provider Participation Fee	213,978	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,998,326	40
41	**Income before Income Taxes (line 30 minus line 40)****	907,306	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 907,306	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,306,049	44
45	Private Pay - Net Inpatient Revenue	1,336,297	45
46	Medicare - Net Inpatient Revenue	676,455	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,318,801	49

* **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.**

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

TAYLORVILLE CARE CENTER, INC.
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII, LINE 28
12/31/2014

OTHER REVENUE:

VOIDED CHECK	$ 750
MISCELLANEOUS	1,126
RENTAL INCOME - LAND	1,350
	$ 3,226

TAYLORVILLE CARE CENTER, INC.
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII
12/31/2014

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	$ 907,306
DEPRECIATION ADJUSTMENT	(11,264)
TRAVEL & ENTERTAINMENT ADJUSTMENT	969
CONVERSION TO CASH BASIS ADJUSTMENTS	(382,201)
TAX NET INCOME	$ 514,810

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,818	2,084	$ 73,977	$ 35.50	1
2	Assistant Director of Nursing	1,581	1,686	40,954	24.29	2
3	Registered Nurses	4,457	4,753	101,855	21.43	3
4	Licensed Practical Nurses	26,522	27,622	489,499	17.72	4
5	CNAs & Orderlies	68,019	69,229	696,803	10.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,538	3,720	36,490	9.81	10
11	Social Service Workers	3,674	3,804	40,925	10.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,591	16,356	154,192	9.43	15
16	Dishwashers					16
17	Maintenance Workers	4,764	5,014	69,725	13.91	17
18	Housekeepers	12,728	13,202	125,664	9.52	18
19	Laundry	3,602	3,990	36,014	9.03	19
20	Administrator	1,901	2,262	93,167	41.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,865	2,067	23,828	11.53	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	1,940	2,068	21,542	10.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,000	157,857	$ 2,004,635 *	$ 12.70	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	165	$ 8,785	1,3	35
36	Medical Director	Contract	9,600	9,3	36
37	Medical Records Consultant	34	2,458	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	3,466	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	73	5,028	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Music Therapy	Contract	0	10,3	47
48					48
49	TOTAL (lines 35 - 48)	272	$ 29,337		49

C. CONTRACT NURSES

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rhonda Hancock	Administrator	0	$ 93,167
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,167

B. Administrative - Other

Description	Amount
Management Fee	$ 253,486
TOTAL (agree to Schedule V, line 17, col. 3)	$ 253,486
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accounting	$ 13,725
Greensfedler, Hemker & Gale	Legal	660
Mathis, Marifian & Richter	Collection (Eliminated)	10,114
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 24,499

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,189
Unemployment Compensation Insurance	66,535
FICA Taxes	150,815
Employee Health Insurance	16,288
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	0
Employee Relations	1,377
Pension Expense	761
Home Office Allocation	10,053
TOTAL (agree to Schedule V, line 22, col.8)	$ 298,018

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,623
Health Care Worker Background Check	455
(Indicate # of checks performed)	
Patient Background Checks	455
IHCA Dues	3,443
Miscellaneous Dues & Licenses	2,300
Home Office Allocation	150
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,416

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	694
Seminar Expense	3,644
Home Office Allocation	1,395
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,733

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA Dues $3,443**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **651** 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. $ **213,978**
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? **Yes** Indicate the amount. $ **276**

(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? **81.87**
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. $ **No**

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

TAYLORVILLE CARE CENTER 2014

ATTACHMENT TO SCHEDULE XX, SECTION G

NAME OF EMPLOYEE ATTENDING SEMINAR	JOB TITLE	DATE	LOCATION	SEMINAR TITLE	SEMINAR SPONSOR	SEMINAR COST	TRAVEL/ LODGING COST
Rhonda Hancock Kelly Walter Erin Hogge Chantel Murphy	Admin. DON	1/29/14	Web-seminar	Reg 48	IHCA	120.00	
Rhonda Hancock Kelly Walter Erin Hogge Chantel Murphy	Admin. DON	2/13/14	Web-seminar	ICD-10	IHCA	120.00	
Rhonda Hancock Kelly Walter	Admin. DON	6/11-12/14	S. Peoria, IL	Conference	INHAA	190.00	110.88
Rhonda Hancock	Admin.	5/2014	Web-seminar		IHCA	75.00	
Rhonda Hancock	Admin.	6/2014	Web-seminar	Pepper,Oscar, QMS & 5 Star	IHCA	75.00	
Rhonda Hancock Kelly Walter Alnaca Vail Maria Belsher	Admin. DON Activity CNA	10/14/14	Springfield	Summit Meeting	IL Pioneer	720.00	
Rhonda Hancock Kelly Walter	Admin. DON	10/29/14	Springfield, IL	National Conv.	INHAA	2344.10	549.57 33.60
						$3664.10	$694.05