

Facility Name & ID Number Taylorville Care Center

0028787 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	320	120	2,547	2,987	8
9	SNF/PED					9
10	ICF	15,513	9,737		25,250	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,833	9,857	2,547	28,237	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.94%

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 2,547

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Taylorville Care Center

0028787

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	147,915	10,592	9,659	168,166		168,166		168,166		1
2	Food Purchase		157,830		157,830		157,830	(1,428)	156,402		2
3	Housekeeping	106,300	17,684		123,984		123,984	842	124,826		3
4	Laundry	45,279	14,482		59,761		59,761		59,761		4
5	Heat and Other Utilities			97,812	97,812		97,812	(5,566)	92,246		5
6	Maintenance	70,722	47,847	8,792	127,361		127,361	982	128,343		6
7	Other (specify):* Sanitation			6,918	6,918		6,918		6,918		7
8	TOTAL General Services	370,216	248,435	123,181	741,832		741,832	(5,170)	736,662		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,379,298	86,689	6,259	1,472,246		1,472,246		1,472,246		10
10a	Therapy										10a
11	Activities	46,331	3,776	5,034	55,141		55,141		55,141		11
12	Social Services	42,113			42,113		42,113		42,113		12
13	CNA Training										13
14	Program Transportation		6,130		6,130		6,130		6,130		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,467,742	96,595	20,893	1,585,230		1,585,230		1,585,230		16
	C. General Administration										
17	Administrative	86,311	1,578	170,000	257,889		257,889	(89,117)	168,772		17
18	Directors Fees										18
19	Professional Services			44,426	44,426		44,426	(2,096)	42,330		19
20	Dues, Fees, Subscriptions & Promotions			15,889	15,889		15,889	(2,689)	13,200		20
21	Clerical & General Office Expenses	24,151	10,336	65,260	99,747		99,747	59,509	159,256		21
22	Employee Benefits & Payroll Taxes			237,667	237,667		237,667	8,990	246,657		22
23	Inservice Training & Education			1,664	1,664		1,664		1,664		23
24	Travel and Seminar			2,857	2,857		2,857	370	3,227		24
25	Other Admin. Staff Transportation			2,367	2,367		2,367	506	2,873		25
26	Insurance-Prop.Liab.Malpractice			95,432	95,432		95,432	1,237	96,669		26
27	Other (specify):*										27
28	TOTAL General Administration	110,462	11,914	635,562	757,938		757,938	(23,290)	734,648		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,948,420	356,944	779,636	3,085,000		3,085,000	(28,460)	3,056,540		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: 01/01/2015 Ending: 12/31/2015

12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			74,760	74,760		74,760	6,328	81,088			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			50,095	50,095		50,095	1,122	51,217			33
34	Rent-Facility & Grounds			50	50		50	1,070	1,120			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			124,905	124,905		124,905	8,520	133,425			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,755	287,829	390,584		390,584		390,584			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			211,932	211,932		211,932		211,932			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		102,755	499,761	602,516		602,516		602,516			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,948,420	459,699	1,404,302	3,812,421		3,812,421	(19,940)	3,792,481			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: 01/01/2015

Ending: 12/31/2015

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	(149)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,218)	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	(1,279)	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	(110)	17		19
20	Contributions	(585)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,726)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,720)	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	(2,963)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (21,750)		\$	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)	1,810	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,810		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (19,940)		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
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Taylorville Care Center

ID# 0028787

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	To eliminate lobbying portion of IHCA dues	\$ (2,082)	20	1
2	Adjust depreciation for cost report purposes	(2,492)	30	2
3	Eliminate Chamber of Commerce Dues	(379)	20	3
4	Adjust for 2015 License paid in 2014	1,990	20	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
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(2,963)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	(1,428)	0	0	0	0	0	0	0	0	0	0	(1,428)	2
3	Housekeeping	0	842	0	0	0	0	0	0	0	0	0	842	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,218)	652	0	0	0	0	0	0	0	0	0	(5,566)	5
6	Maintenance	0	982	0	0	0	0	0	0	0	0	0	982	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,646)	2,476	0	(5,170)	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	(110)	(89,007)	0	0	0	0	0	0	0	0	0	(89,117)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,726)	6,630	0	0	0	0	0	0	0	0	0	(2,096)	19
20	Fees, Subscriptions & Promotions	(2,776)	87	0	0	0	0	0	0	0	0	0	(2,689)	20
21	Clerical & General Office Expenses	0	59,509	0	0	0	0	0	0	0	0	0	59,509	21
22	Employee Benefits & Payroll Taxes	0	8,990	0	0	0	0	0	0	0	0	0	8,990	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	370	0	0	0	0	0	0	0	0	0	370	24
25	Other Admin. Staff Transportation	0	506	0	0	0	0	0	0	0	0	0	506	25
26	Insurance-Prop.Liab.Malpractice	0	1,237	0	0	0	0	0	0	0	0	0	1,237	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(11,612)	(11,678)	0	(23,290)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,258)	(9,202)	0	(28,460)	29								

STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center# 0028787

Report Period Beginning:

01/01/2015 Ending:

Summary B

12/31/2015

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	(2,492)	8,820	0	0	0	0	0	0	0	0	0	6,328	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	1,122	0	0	0	0	0	0	0	0	0	1,122	33
34	Rent-Facility & Grounds	0	0	1,070	0	0	0	0	0	0	0	0	1,070	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	(2,492)	9,942	1,070	0	8,520	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)	(21,750)	740	1,070	0	(19,940)	45							

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 2011 Exempt Trust	20	Mt. Vernon Countryside Manor, Inc.	Mt. Vernon, IL	King Management Co.	Nashville, IL	Home Office
Leslie Peditke 2011 Exempt Trust	20	Aviston Countryside Manor, Inc.	Aviston, IL	Residential Living Ctr	Mt. Vernon, IL	Assisted Living
Keith King 2011 Exempt Trust	20			Taylorville Estates	Taylorville, IL	Assisted Living
Elizabeth Todorov 2011 Exempt Trust	20			Trenton Village	Trenton, IL	Assisted Living
Michelle Hirschfield 2011 Exempt Trust	20					

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 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%	\$ 842	\$ 842	1
2	V	5 See Schedule VIII		King Management Company	0.00%	652	652	2
3	V	6 See Schedule VIII		King Management Company	0.00%	982	982	3
4	V	17 See Schedule VIII	170,000	King Management Company	0.00%	80,993	(89,007)	4
5	V	19 See Schedule VIII		King Management Company	0.00%	6,630	6,630	5
6	V	20 See Schedule VIII		King Management Company	0.00%	87	87	6
7	V	21 See Schedule VIII		King Management Company	0.00%	59,509	59,509	7
8	V	22 See Schedule VIII		King Management Company	0.00%	8,990	8,990	8
9	V	24 See Schedule VIII		King Management Company	0.00%	370	370	9
10	V	25 See Schedule VIII		King Management Company	0.00%	506	506	10
11	V	26 See Schedule VIII		King Management Company	0.00%	1,237	1,237	11
12	V	30 See Schedule VIII		King Management Company	0.00%	8,820	8,820	12
13	V	33 See Schedule VIII		King Management Company	0.00%	1,122	1,122	13
14	Total		\$ 170,000			\$ 170,740	\$ * 740	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 See Schedule VIII	\$	King Management Company	0.00%	\$ 1,070	\$	1,070	15
16	V								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		\$			\$ 1,070	\$ *	1,070	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Denise King	President	Administrative	0.00	190,866	16	26.74	Salary	\$ 80,480	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 80,480		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:

01/01/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization King Management Company
 Street Address 935 South Mill Street
 City / State / Zip Code Nashville, IL62263
 Phone Number (618) 327-3064
 Fax Number (618) 327-3083

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Accumulated Costs	13,620,982	6	\$ 3,148	\$ 3,642,422	\$ 842	1
2	5	Utilities	Accumulated Costs	13,620,982	6	2,438	3,642,422	652	2
3	6	Maintenance	Accumulated Costs	13,620,982	6	3,671	3,642,422	982	3
4	17	Administrative	Accumulated Costs	13,620,982	6	302,877	300,960	80,993	4
5	19	Professional Fees	Accumulated Costs	13,620,982	6	24,792	3,642,422	6,630	5
6	20	Dues, Fees, & Subscriptions	Accumulated Costs	13,620,982	6	327	3,642,422	87	6
7	21	Clerical & Office Expense	Accumulated Costs	13,620,982	6	222,536	186,486	59,509	7
8	22	Emp Benefits & Payroll Taxes	Accumulated Costs	13,620,982	6	33,619	3,642,422	8,990	8
9	24	Travel & Seminar	Accumulated Costs	13,620,982	6	1,385	3,642,422	370	9
10	25	Other Administrative Transp.	Accumulated Costs	13,620,982	6	1,892	3,642,422	506	10
11	26	Insurance	Accumulated Costs	13,620,982	6	4,627	3,642,422	1,237	11
12	30	Depreciation	Accumulated Costs	13,620,982	6	32,981	3,642,422	8,820	12
13	33	Real Estate Taxes	Accumulated Costs	13,620,982	6	4,194	3,642,422	1,122	13
14	34	Rental	Accumulated Costs	13,620,982	6	4,000	3,642,422	1,070	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 642,487	\$ 487,446	\$ 171,810	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787 Report Period Beginning: 01/01/2015

Ending: 2/31/2015

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Taylorville Care Center

0028787

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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						\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2014 report.		\$	48,000		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.)		\$	48,095		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	95		3														
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	50,000		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.		\$	50,095		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>46,894</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>46,993</u>	9																
	2012	<u>47,277</u>	10																
	2013	<u>47,853</u>	11																
	2014	<u>48,095</u>	12																
Line 4: Based on 2014 Taxes paid plus inflationary increase																			
Line 7 R.E. Tax Expense - Facility		50,095																	
Home Office Allocation		1,122																	
Total Real Estate Tax Expense - Schedule V		51,217																	

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2014 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 2014 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 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-13-28-401-005-00</u>	<u>Cheneys Add Lts 1 Thru 6 Blk 3</u>	\$ <u>48,094.96</u>	\$ <u>48,094.96</u>
2. _____	<u>& Lts 1 Thru 6 Blk 4 & OL 1 &</u>	\$ _____	\$ _____
3. _____	<u>Vac Austin St. & Alley</u>	\$ _____	\$ _____
4. _____	<u>282X652 13-28-G</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>48,094.96</u></u>	\$ <u><u>48,094.96</u></u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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:

01/01/2015 Ending:

12/31/2015

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>	1
2					2
3	TOTALS	186,200		\$ 40,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$	\$	\$ 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		Nurse' 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		824	20
21		4 Inch Backflow Preventer		1994	3,966	159	25	159		3,490	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	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		20,240	41
42	Water Heater	2001	5,800	387	15	387		5,607	42
43	Wallpaper & Installation	2002	9,016		5			9,016	43
44	Wallguards	2002	5,729	382	15	382		5,252	44
45	Water Heater	2002	6,759	451	15	451		5,971	45
46	Carpet/Baseboard Remodel	2002	16,561		10			16,561	46
47	Landscaping	2004	5,106		10			5,106	47
48	20' Gazebo	2004	24,761	1,651	15	1,651		18,571	48
49	Parking Lot	2004	27,200		8			27,200	49
50	Lawn Sprinkler System	2004	3,850	257	15	257		2,909	50
51	Landscaping	2004	8,977		10			8,977	51
52	Vinyl Fence	2004	5,219		10			5,219	52
53	Facility Sign	2004	2,632		10			2,632	53
54	100 Gallon Water Heater	2004	2,390		10			2,390	54
55	Sidewalk	2004	1,920	128	15	128		1,451	55
56	Telephone System	2004	4,337		10			4,337	56
57	Concrete Sidewalk	2005	3,100	207	15	207		2,119	57
58	Storage Building	2006	4,030	202	20	202		1,831	58
59	Fire System Upgrade	2007	5,577	558	7		(558)	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		2,079	63
64	Sidewalk	2007	6,785	338	15	451	113	3,618	64
65	Water Softener System	2010	4,700	470	10	470		2,468	65
66	Tile Flooring	2010	2,244	224	10	224		1,196	66
67	Plumbing Upgrades	2010	21,525	1,076	20	1,076		6,278	67
68	Ceramic Tile	2010	15,575	779	20	779		3,959	68
69	Vinyl Tile	2010	1,320	132	10	132		660	69
70	TOTAL (lines 4 thru 69)		\$ 2,108,548	\$ 9,041		\$ 8,596	\$ (445)	\$ 2,053,753	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2015 Ending: 12/31/2015

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,108,548	\$ 9,041		\$ 8,596	\$ (445)	\$ 2,053,753	1
2	Ceramic Tile	2010	32,565	1,628	20	1,628		8,412	2
3	Light Fixtures	2011	2,422	242	10	242		1,090	3
4	Cabinetry & Built-In Deck for Therapy	2011	5,898	393	15	393		1,802	4
5	Roof	2011	50,303	3,353	15	3,353		14,811	5
6	Cherry Flooring	2011	14,258	1,426	10	1,426		6,060	6
7	Shower Room Tile	2011	3,477	232	15	232		1,024	7
8	Flat Roof	2011	11,269	1,127	10	1,127		4,883	8
9	Roof & Parapet Wall	2011	51,757	3,450	15	3,450		13,801	9
10	Wallpaper & Border	2011	8,393	1,679	5	1,679		6,855	10
11	Tile Flooring Installation	2011	10,000	1,000	10	1,000		4,083	11
12	Custom Nurses' Station	2011	27,690	1,846	15	1,846		7,538	12
13	Hand Rail & Crash Rail	2011	8,946	596	15	596		2,435	13
14	Water Heater	2012	4,114	411	10	411		1,611	14
15	Walk-In Cooler Condensing Unit	2012	2,774	185	15	185		632	15
16	Building Generator	2013	51,847	2,592	20	2,592		5,616	16
17	Gazebo	2013	1,257	84	15	84		196	17
18	Concrete Drive	2013	12,954	864	15	864		2,231	18
19	Concrete Dumpster Pad & Walk	2013	3,700	247	15	247		576	19
20	Cabines & Countertop	2013	3,010	201	15	201		402	20
21	Rooftop A/C System - 5-ton	2013	5,288	529	10	529		1,058	21
22	Paint Ceilings in A & C	2014	11,643	2,329	5	2,329		4,464	22
23	Paint Ceilings in Main Hallway	2014	2,800	560	5	560		1,027	23
24	Paint Ceilings in 15 Rooms	2014	9,000	1,800	5	1,800		2,550	24
25	Hallway Lighting	2014	2,080	208	10	208		364	25
26	Fitness Room Lighting	2014	2,430	243	10	243		405	26
27	5-ton Roof-Top HVAC	2014	5,352	357	15	357		387	27
28	Cable Wiring A Hall	2014	2,600	144	18	144		203	28
29	100 gal Water Heater	2015	5,157	215	10	215		215	29
30	New Steel Service Door & Frame	2015	8,268	34	20	34		34	30
31	Concrete Work	2015	3,650	61	15	61		61	31
32	Additional 2011 Assets			737			(737)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,473,450	\$ 37,814		\$ 36,632	\$ (1,182)	\$ 2,148,579	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 2,473,450	\$ 37,814		\$ 36,632	\$ (1,182)	\$ 2,148,579	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	
31								31	
32								32	
33								33	
34	TOTAL (lines 1 thru 33)	\$ 2,473,450	\$ 37,814		\$ 36,632	\$ (1,182)	\$ 2,148,579	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

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 12C, Carried Forward		\$ 2,473,450	\$ 37,814		\$ 36,632	\$ (1,182)	\$ 2,148,579	1
2	Home Office Additions:								2
3	New Building - Sold in 2015	1995			25	612	612		3
4	Cabinets - Sold in 2015	1996			20	26	26		4
5	Front Door	2002	428		10			428	5
6	Wallpaper	2007	244		10	24	24	199	6
7	Wallpaper	2008	2,006		5			2,006	7
8	Carpet	2008	2,472		5			2,472	8
9	Tile Flooring	2009	171		10	17	17	120	9
10	Wallpaper	2009	384		5			384	10
11	Air Conditioner - Sold in 2015	2013			10	35	35		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	TOTAL (lines 1 thru 33)		\$ 2,479,155	\$ 37,814		\$ 37,346	\$ (468)	\$ 2,154,188	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 315,146	\$ 36,772	\$ 37,857	\$ 1,085	3-20 Years	\$ 152,855	71
72	Current Year Purchases	2,615	174	174		3-10 Years	174	72
73	Fully Depreciated Assets	293,761					293,761	73
74								74
75	TOTALS	\$ 611,522	\$ 36,946	\$ 38,031	\$ 1,085		\$ 446,790	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	Chevrolet Bus	2007	\$ 28,000	\$	\$	\$	4	\$ 28,000	76
77										77
78										78
79	Home Office Vehicles	Various	Various	22,843		5,711	5,711	4	12,656	79
80	TOTALS			\$ 50,843	\$	\$ 5,711	\$ 5,711		\$ 40,656	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)	\$ 3,181,520	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 74,760	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,088	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,328	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,641,634	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: _____ *

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

15. Is Movable equipment rental included in building rental?

YES N/A NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2015 Ending: 12/31/2015
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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	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				100,835		100,835	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Therapy</u>	39,3				268,364			268,364	12
13	Other (specify): <u>Labs,X-ray,Ambul,Sup</u>	39,3 & 39,2				19,465	1,920		21,385	13
14	TOTAL			\$		\$ 287,829	\$ 102,755		\$ 390,584	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: 01/01/2015

Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	\$ 913,058	\$	1
2	Cash-Patient Deposits	8,352		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,519,369		3
4	Supply Inventory (priced at Cost)	6,294		4
5	Short-Term Investments			5
6	Prepaid Insurance	68,453		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,515,526	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	2,448,280		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	609,026		16
17	Accumulated Depreciation (book methods)	(2,571,107)		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)	\$ 526,199	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,041,725	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 69,547	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,352		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	133,327		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,555		31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Management Company</u>			36
37	<u>Accrued Provider Taxes</u>	24,329		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 305,110	\$	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	<u>Due to Prior Shareholder</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 305,110	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,736,615	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,041,725	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,128,897	1
2	Restatements (describe):		2
3	APIC from fixed assets	43,753	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,172,650	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	990,550	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	(426,585)	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)	\$ 563,965	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)	\$ 2,736,615	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,038,649	1
2	Discounts and Allowances for all Levels	(1,115,370)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,923,279	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	863,350	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 863,350	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	149	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	8,867	19
20	Radiology and X-Ray	5,943	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 14,959	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	709	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 709	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	674	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 674	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,802,971	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	741,832	31
32	Health Care	1,585,230	32
33	General Administration	757,938	33
B. Capital Expense			
34	Ownership	124,905	34
C. Ancillary Expense			
35	Special Cost Centers	390,584	35
36	Provider Participation Fee	211,932	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,812,421	40
41	Income before Income Taxes (line 30 minus line 40)**	990,550	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 990,550	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,827,409	44
45	Private Pay - Net Inpatient Revenue	1,619,722	45
46	Medicare - Net Inpatient Revenue	476,147	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,923,279	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.

SEE ACCOUNTANTS' COMPILATION REPORT

TAYLORVILLE CARE CENTER, INC.
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII
12/31/2015

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 990,550
DEPRECIATION ADJUSTMENT	29,948
TRAVEL & ENTERTAINMENT ADJUSTMENT	55
CONVERSION TO CASH BASIS ADJUSTMENTS	(174,036)
TAX NET INCOME	<u>\$ 846,517</u>

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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	1,951	2,224	\$ 72,397	\$ 32.55	1
2	Assistant Director of Nursing	1,619	1,919	44,458	23.17	2
3	Registered Nurses	7,055	7,568	166,903	22.05	3
4	Licensed Practical Nurses	22,641	23,584	425,852	18.06	4
5	CNAs & Orderlies	60,431	61,473	647,788	10.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,423	4,606	46,331	10.06	10
11	Social Service Workers	3,702	3,958	42,113	10.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,053	15,624	147,915	9.47	15
16	Dishwashers					16
17	Maintenance Workers	4,772	4,991	70,722	14.17	17
18	Housekeepers	11,136	11,875	106,300	8.95	18
19	Laundry	4,391	4,767	45,279	9.50	19
20	Administrator	1,883	2,070	86,311	41.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,874	2,055	24,151	11.75	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	1,929	2,073	21,900	10.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,860	148,787	\$ 1,948,420 *	\$ 13.10	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	178	\$ 9,659	1,3	35
36	Medical Director	Contract	9,600	9,3	36
37	Medical Records Consultant	33	2,425	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	3,834	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	71	5,034	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Music Therapy				47
48					48
49	TOTAL (lines 35 - 48)	282	\$ 30,552		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule Not Applicable	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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 \$3,504
- (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. \$ 652 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 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. \$ 211,932
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 149
- (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?
- 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.