

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0028787

Facility Name: Taylorville Care Center

Address: 600 S Houston Taylorville 62568
Number City 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
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ 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 01/01/2012 to 12/31/2012 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center# 0028787 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,868</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,868</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>922</u>	<u>802</u>	<u>2,761</u>	<u>4,485</u>	8
9	SNF/PED					9
10	ICF	<u>16,465</u>	<u>7,457</u>		<u>23,922</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,387</u>	<u>8,259</u>	<u>2,761</u>	<u>28,407</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 79.20%

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?

YesG. 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 08/01/1984NO ☐

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 2,761Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	162,910	12,514	8,646	184,070	291	184,361		184,361		1
2	Food Purchase		169,575		169,575		169,575	(1,744)	167,831		2
3	Housekeeping	124,961	16,534		141,495		141,495	819	142,314		3
4	Laundry	52,770	13,764		66,534		66,534		66,534		4
5	Heat and Other Utilities			95,130	95,130		95,130	(4,076)	91,054		5
6	Maintenance	56,961	41,534	4,800	103,295		103,295	38,310	141,605		6
7	Other (specify):* Sanitation			9,673	9,673		9,673		9,673		7
8	TOTAL General Services	397,602	253,921	118,249	769,772	291	770,063	33,309	803,372		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,447,717	103,299	4,777	1,555,793		1,555,793	(35)	1,555,758		10
10a	Therapy										10a
11	Activities	37,456	4,508	5,156	47,120	(791)	46,329	(260)	46,069		11
12	Social Services	39,209			39,209	65	39,274		39,274		12
13	CNA Training										13
14	Program Transportation		6,439		6,439		6,439		6,439		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,524,382	114,246	19,533	1,658,161	(726)	1,657,435	(295)	1,657,140		16
	C. General Administration										
17	Administrative	72,805	16,598	320,000	409,403	(3,769)	405,634	(117,724)	287,910		17
18	Directors Fees										18
19	Professional Services			28,462	28,462		28,462	(209)	28,253		19
20	Dues, Fees, Subscriptions & Promotions			19,910	19,910	4,204	24,114	(12,930)	11,184		20
21	Clerical & General Office Expenses	24,012	15,775	92,011	131,798		131,798	60,287	192,085		21
22	Employee Benefits & Payroll Taxes			347,093	347,093		347,093	18,614	365,707		22
23	Inservice Training & Education			1,467	1,467		1,467		1,467		23
24	Travel and Seminar			3,069	3,069		3,069	696	3,765		24
25	Other Admin. Staff Transportation			469	469		469	4,640	5,109		25
26	Insurance-Prop.Liab.Malpractice			65,066	65,066		65,066	1,526	66,592		26
27	Other (specify):*										27
28	TOTAL General Administration	96,817	32,373	877,547	1,006,737	435	1,007,172	(45,100)	962,072		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,018,801	400,540	1,015,329	3,434,670		3,434,670	(12,086)	3,422,584		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			71,910	71,910		71,910	10,800	82,710			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			47,100	47,100		47,100	864	47,964			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			119,010	119,010		119,010	11,664	130,674			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,107	284,029	349,136		349,136		349,136			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			286,061	286,061		286,061		286,061			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		65,107	570,090	635,197		635,197		635,197			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,018,801	465,647	1,704,429	4,188,877		4,188,877	(422)	4,188,455			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(560)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,237)	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	(1,184)	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	(5,070)	17		18
19	Entertainment	(4,128)	17		19
20	Contributions	(685)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,455)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,692)	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	(4,865)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,876)		\$	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)	38,454	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 38,454		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (422)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Taylorville Care Center

Report Period Beginning:

Ending:

ID#002878701/01/201212/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Eliminate Non-Allowable Dues	\$ (749)	17	1
2	Straight Line Depr. On Items Req'd To Be Capitalized	352	30	2
3	Eliminate Lobbying Portion of 2012 IHCA Dues	(1,913)	20	3
4	Offset Miscellaneous Activities Department Income	(260)	11	4
5	Offset Reimbursements for Copies of Medical Records	(35)	10	5
6	Eliminate 2013 IDPH License Paid in 2012	(1,990)	20	6
7	Eliminate Non-Allowable Dues	(270)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,865)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	(1,744)	0	0	0	0	0	0	0	0	0	0	(1,744)	2
3	Housekeeping	0	819	0	0	0	0	0	0	0	0	0	819	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,237)	1,161	0	0	0	0	0	0	0	0	0	(4,076)	5
6	Maintenance	0	38,310	0	0	0	0	0	0	0	0	0	38,310	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,981)	40,290	0	0	0	0	0	0	0	0	0	33,309	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	(35)	0	0	0	0	0	0	0	0	0	0	(35)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(260)	0	0	0	0	0	0	0	0	0	0	(260)	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	(295)	0	0	0	0	0	0	0	0	0	0	(295)	16
	C. General Administration													
17	Administrative	(9,947)	91,853	(199,630)	0	0	0	0	0	0	0	0	(117,724)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,455)	6,510	1,736	0	0	0	0	0	0	0	0	(209)	19
20	Fees, Subscriptions & Promotions	(13,550)	605	15	0	0	0	0	0	0	0	0	(12,930)	20
21	Clerical & General Office Expenses	0	60,287	0	0	0	0	0	0	0	0	0	60,287	21
22	Employee Benefits & Payroll Taxes	0	14,905	3,709	0	0	0	0	0	0	0	0	18,614	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	696	0	0	0	0	0	0	0	0	696	24
25	Other Admin. Staff Transportation	0	4,640	0	0	0	0	0	0	0	0	0	4,640	25
26	Insurance-Prop.Liab.Malpractice	0	1,526	0	0	0	0	0	0	0	0	0	1,526	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(31,952)	180,326	(193,474)	0	0	0	0	0	0	0	0	(45,100)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(39,228)	220,616	(193,474)	0	0	0	0	0	0	0	0	(12,086)	29

STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2012 Ending:

Summary B
12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	352	10,448	0	0	0	0	0	0	0	0	0	10,800	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	864	0	0	0	0	0	0	0	0	0	864	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	352	11,312	0	0	0	0	0	0	0	0	0	11,664	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)	(38,876)	231,928	(193,474)	0	0	0	0	0	0	0	0	(422)	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	Aviston Countryside Manor, Inc.	Aviston	King Management	Nashville, IL	Home Office
Leslie Pedtke 2011 Exempt Trust	20	Mt. Vernon Countryside Manor, Inc.	Mt. Vernon	King Management	Bonita Springs, FL	Management Co.
Keith King 2011 Exempt Trust	20			of SW Florida		
Elizabeth Todorov 2011 Exempt Trust	20			Residential Living Ctr	Mt. Vernon	Assisted Living
Michelle Hirschfeld 2011 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.

☒ 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	100.00%	\$ 819	\$ 819	1
2	V	5	See Schedule VIII		King Management Company	100.00%	1,161	1,161	2
3	V	6	See Schedule VIII		King Management Company	100.00%	38,310	38,310	3
4	V	17	See Schedule VIII		King Management Company	100.00%	91,853	91,853	4
5	V	19	See Schedule VIII		King Management Company	100.00%	6,510	6,510	5
6	V	20	See Schedule VIII		King Management Company	100.00%	605	605	6
7	V	21	See Schedule VIII		King Management Company	100.00%	60,287	60,287	7
8	V	22	See Schedule VIII		King Management Company	100.00%	14,905	14,905	8
9	V	25	See Schedule VIII		King Management Company	100.00%	4,640	4,640	9
10	V	26	See Schedule VIII		King Management Company	100.00%	1,526	1,526	10
11	V	30	See Schedule VIII		King Management Company	100.00%	10,448	10,448	11
12	V	33	See Schedule VIII		King Management Company	100.00%	864	864	12
13	V								13
14	Total			\$			\$ 231,928	\$ * 231,928	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	17	See Schedule VIII	\$ 320,000	King Management of SW Florida	100.00%	\$ 120,370	\$ (199,630)	15
16	V	19	See Schedule VIII		King Management of SW Florida	100.00%	1,736	1,736	16
17	V	20	See Schedule VIII		King Management of SW Florida	100.00%	15	15	17
18	V	22	See Schedule VIII		King Management of SW Florida	100.00%	3,709	3,709	18
19	V	24	See Schedule VIII		King Management of SW Florida	100.00%	696	696	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			\$ 320,000			\$ 126,526	\$ * (193,474)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jerry King	Mgt. Co. Owner	Mgmt/Consultant	0.00	292,067	13	26.15	Salary	\$ 118,802	17, 8	1
2	Denise King	V.P. of Operations	Administrative	20.00	224,969	16	26.15	Salary	91,509	17, 8	2
3	Keith King	Maint. Supervisor	Maintenance	20.00	92,280	13	26.15	Salary	37,536	6, 8	3
4	Marilyn King	Mgt. Co. Owner	Mgmt/Consultant	0.00	3,856	1	26.15	Salary	1,569	17,8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 249,416		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

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.) 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 2011 report.		\$	46,993	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.)		\$	46,993	2	
3. Under or (over) accrual (line 2 minus line 1).		\$		3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	47,100	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.		\$	47,100	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	44,205	8	
		2008	45,791	9	
		2009	46,182	10	
		2010	46,894	11	
		2011	46,993	12	
Line 4: Accrual based on 2011 taxes paid.					
Line 7: Real Estate Tax Expense \$47,100		Line 1: \$47,500		2011 Accrual per report	
Home Office Allocation 864		(507)		Prior Year Retained Earnings Adjustment	
Total Real Estate Tax \$47,964		\$46,993			
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2011 \$	13	
		14	PLUS APPEAL COST FROM LINE 5 \$	14	
		15	LESS REFUND FROM LINE 6 \$	15	
		16	AMOUNT TO USE FOR RATE CALCULATION \$	16	

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 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 2011 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 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	17-13-28-401-005-00	Cheneys Add Lts 1 Thru 6 Blk 3	\$ 46,993.46	\$ 46,993.46
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	\$ 46,993.46	\$ 46,993.46

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,610

B. General Construction Type: Exterior BrickFrame Non-Comb Sprinkle

Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 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	1,644	2
3	TOTALS	186,200		\$ 41,644	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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
5										
6										
7										
8										
	Improvement Type**									
9	80 Gallon Water Fixture		1985		1,581		10			1,581
10	Improvements to Building		1985		12,510		25			12,510
11	Improvements to Parking Lot		1986		1,184		10			1,184
12	New Light Fixtures		1987		997		10			997
13	Tile Floor		1987		5,941		10			5,941
14	Roof		1988		55,100		10			55,100
15	Addition to Alarm System		1988		5,610		10			5,610
16	Concrete Driveway		1989		2,729		15			2,729
17	Nurses' Station		1991		4,809		15			4,809
18	Water Heater		1993		3,750		15			3,750
19	Air Conditioner		1993		2,800		10			2,800
20	New Office		1993		1,500	37	40	37		713
21	4 Inch Backflow Preventer		1994		3,966	159	25	159		3,014
22	Carpeting		1994		2,471		10			2,471
23	Circulating Pump on Water Heater		1994		2,450		14			2,450
24	Fence		1995		3,590		15			3,590
25	Water Heater		1995		1,602		15			1,602
26	Sprinkler Heads		1995		1,600		15			1,600
27	New Roof		1996		25,000		10			25,000
28	Water Softener		1996		5,908		10			5,908
29	Ceramic Tile		1997		5,167		10			5,167
30	Garage		1997		7,841		10			7,841
31	Rooftop A/C, Ducts and Gas Lines		1997		10,940		10			10,940
32	Beauty Shop Addition		1997		6,823	455	15	455		6,823
33	Carpeting		1998		4,154		10			4,154
34	Windows		1998		5,681		10			5,681
35										
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:

01/01/2012

Ending:

12/31/2012

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	Heating and A/C Units	1998	\$ 4,128	\$	5	\$	\$	\$ 4,128	37
38	Air Conditioner Units	1999	25,051		10			25,051	38
39	Rear Parking Lot/Driveway	1999	2,995		10			2,995	39
40	Air Conditioner Units	2000	4,834		10			4,834	40
41	Landscaping	2001	2,300		10			2,300	41
42	Electrical	2001	6,725		10			6,725	42
43	Cabinets	2001	27,445	1,372	20	1,372		16,124	43
44	Water Heater	2001	5,800	387	15	387		4,447	44
45	Wallpaper & Installation	2002	9,016		5			9,016	45
46	Wallguards	2002	5,729	382	15	382		4,106	46
47	Water Heater	2002	6,759	451	15	451		4,619	47
48	Carpet/Baseboard Remodel	2002	16,561	414	10	414		16,561	48
49	Landscaping	2004	5,106	511	10	511		4,212	49
50	20' Gazebo	2004	24,761	1,651	15	1,651		13,618	50
51	Parking Lot	2004	27,200	2,550	8	2,550		27,200	51
52	Lawn Sprinkler System	2004	3,850	257	15	257		2,139	52
53	Landscaping	2004	8,977	898	10	898		7,331	53
54	Vinyl Fence	2004	5,219	522	10	522		4,219	54
55	Facility Sign	2004	2,632	263	10	263		2,193	55
56	100 Gallon Water Heater	2004	2,390	239	10	239		2,011	56
57	Sidewalk	2004	1,920	128	15	128		1,067	57
58	Telephone System	2004	4,337	434	10	434		3,506	58
59	Concrete Sidewalk	2005	3,100	207	15	207		1,498	59
60	Storage Building	2006	4,030	201	20	201		1,226	60
61	Fire System Upgrade	2007	5,577	557	7	796	239	4,714	61
62	Carpet/Baseboard Remodel	2007	31,573	2,105	5	2,105		31,573	62
63	Wallpaper	2007	43,285	7,214	5	7,214		43,285	63
64	Wallpaper	2007	17,086	3,132	5	3,132		17,086	64
65	Rooftop Vents	2007	2,309	231	10	231		1,386	65
66	Sidewalk	2007	6,785	339	15	452	113	2,262	66
67	Water Softener System	2010	4,700	470	10	470		1,057	67
68	Tile Flooring	2010	2,244	224	10	224		524	68
69	Plumbing Upgrades	2010	21,525	1,076	20	1,076		3,049	69
70	TOTAL (lines 4 thru 69)		\$ 2,091,653	\$ 26,866		\$ 27,218	\$ 352	\$ 2,020,027	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:

01/01/2012 Ending: 12/31/2012

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,091,653	\$ 26,866		\$ 27,218	\$ 352	\$ 2,020,027	1
2	Ceramic Tile	2010	15,575	779	20	779		1,622	2
3	Vinyl Tile	2010	1,320	132	10	132		264	3
4	Ceramic Tile	2010	32,565	1,628	20	1,628		3,528	4
5	Light Fixtures	2011	2,422	242	10	242		363	5
6	Cabinetry & Built-In Desk for Therapy	2011	5,898	393	15	393		623	6
7	Roof	2011	50,303	3,354	15	3,354		4,751	7
8	Cherry Flooring	2011	14,258	1,426	10	1,426		1,782	8
9	Shower Room Tile	2011	3,477	232	15	232		328	9
10	Flat Roof	2011	11,269	1,127	10	1,127		1,503	10
11	Roof & Parapet Wall	2011	51,757	3,450	15	3,450		3,450	11
12	Wallpaper and Border	2011	8,393	1,679	5	1,679		1,819	12
13	Tile Flooring Installation	2011	10,000	1,000	10	1,000		1,083	13
14	Custom Nurses' Station	2011	27,690	1,846	15	1,846		2,000	14
15	Hand Rail & Crash Rail	2011	8,946	596	15	596		646	15
16	Water Heater	2012	4,114	377	10	377		377	16
17	Walk-In Cooler Condensing Unit	2012	2,774	77	15	77		77	17
18									18
19									19
20	Home Office Parking Lot	1989	517		5			517	20
21	Home Office Building	1995	25,629		25	1,025	1,025	17,598	21
22	Home Office Interior Finishes Lower Level	1996	1,590		15			1,590	22
23	Home Office Carpet	1996	556		5			556	23
24	Home Office Cabinets	1996	879		20	44	44	725	24
25	Home Office Electrical	1996	305		15			305	25
26	Home Office Front Door	2002	418		10	31	31	418	26
27	Home Office Wallpaper	2007	239		10	24	24	123	27
28	Home Office Wallpaper	2008	1,962		5	392	392	1,962	28
29	Home Office Carpet	2008	2,416		5	483	483	2,416	29
30	Home Office Tile	2009	168		10	17	17	67	30
31	Home Office Wallpaper	2009	375		5	75	75	300	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,377,468	\$ 45,204		\$ 47,647	\$ 2,443	\$ 2,070,820	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	\$ 230,406	\$ 19,942	\$ 21,958	\$ 2,016	3-20 years	\$ 72,229	71
72	Current Year Purchases	23,397	6,764	6,764		5-15 years	6,764	72
73	Fully Depreciated Assets	295,498					295,498	73
74								74
75	TOTALS	\$ 549,301	\$ 26,706	\$ 28,722	\$ 2,016		\$ 374,491	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	21,769		6,341	6,341	4	3,360	77
78										78
79										79
80	TOTALS			\$ 49,769	\$	\$ 6,341	\$ 6,341		\$ 31,360	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)	\$ 3,018,182	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 71,910	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 82,710	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,800	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,476,671	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

**

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

9. Option to Buy:☐ YES☐ NO
- Terms: *

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

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

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning
Ending

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

Fiscal Year EndingAnnual Rent

12. /2013 \$
13. /2014 \$
14. /2015 \$

* 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

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

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.)

		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				65,107		65,107	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Therapy</u>	39,3				266,667			266,667	12
13	Other (specify): <u>Lab, X-Ray, Ambul.</u>	39,3				17,362			17,362	13
14	TOTAL			\$		\$ 284,029	\$ 65,107		\$ 349,136	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

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	\$ 348,586	\$	1
2	Cash-Patient Deposits	6,946		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,187,972		3
4	Supply Inventory (priced at Cost)	6,985		4
5	Short-Term Investments			5
6	Prepaid Insurance	10,442		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)	\$ 1,581,021	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	709,880		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	531,149		16
17	Accumulated Depreciation (book methods)	(774,395)		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)	\$ 466,634	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,047,655	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 47,471	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,946		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	138,272		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,109		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,100		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Medicare Billing Fees	10,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 268,898	\$	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)	\$ 268,898	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,778,757	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,047,655	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,556,618	1
2	Restatements (describe):		2
3			3
4	Prior Year Adjustment to accrue Real Estate Taxes	(46,993)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,509,625	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	339,132	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	(70,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 269,132	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)	\$ 1,778,757	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center# 0028787Report Period Beginning: 01/01/2012Ending: 12/31/2012**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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,739,460	1
2	Discounts and Allowances for all Levels	(640,013)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,099,447	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	415,938	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 415,938	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	560	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	10,697	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,257	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	108	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 108	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	295	28
28a	Vending Machine Income	964	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,259	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,528,009	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	769,772	31
32	Health Care	1,658,161	32
33	General Administration	1,006,737	33
	B. Capital Expense		
34	Ownership	119,010	34
	C. Ancillary Expense		
35	Special Cost Centers	349,136	35
36	Provider Participation Fee	286,061	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,188,877	40
41	Income before Income Taxes (line 30 minus line 40)**	339,132	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 339,132	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,086,695	44
45	Private Pay - Net Inpatient Revenue	1,208,542	45
46	Medicare - Net Inpatient Revenue	804,210	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,099,447	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

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	1,885	2,107	\$ 71,885	\$ 34.12	1
2	Assistant Director of Nursing	2,011	2,104	40,920	19.45	2
3	Registered Nurses	6,498	7,159	143,393	20.03	3
4	Licensed Practical Nurses	24,706	26,230	462,227	17.62	4
5	CNAs & Orderlies	68,230	69,792	709,193	10.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,493	3,735	37,456	10.03	10
11	Social Service Workers	3,504	3,779	39,209	10.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,391	17,415	162,910	9.35	15
16	Dishwashers					16
17	Maintenance Workers	3,777	3,925	56,961	14.51	17
18	Housekeepers	11,886	12,804	124,961	9.76	18
19	Laundry	5,782	6,114	52,770	8.63	19
20	Administrator	2,067	2,273	72,805	32.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,908	2,166	24,012	11.09	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	1,849	2,007	20,099	10.01	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,987	161,610	\$ 2,018,801 *	\$ 12.49	34

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	161	\$ 8,194	1,6	35
36	Medical Director	Contract	9,600	9,3	36
37	Medical Records Consultant	29	1,999	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	2,778	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	75	4,365	11,6	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Administrative Consultant	15	500	17,6	47
48					48
49	TOTAL (lines 35 - 48)	280	\$ 27,436		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

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

** See instructions.

STATE OF ILLINOIS

0028787

Report Period Beginning:

01/01/2012

Page 21

Ending: 12/31/2012

Facility Name & ID Number

Taylorville Care Center

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rhonda Baker	Administrator	0	\$ 69,942
Susan Johnson		0	2,308
Jennifer Stephens		0	555
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 72,805

B. Administrative - Other

Description	Amount
Management Fee	\$ 320,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 320,000

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Compnay	Accounting	\$ 19,125
Greensfelder, Hemker & Gale	Legal Fees	882
Mathis, Marifian & Richter	Collection Fees - Eliminated	8,455
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 28,462

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 97,739
Unemployment Compensation Insurance	68,243
FICA Taxes	152,074
Employee Health Insurance	26,654
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,220
Pension Expense	981
Employee Physicals	182
Home Office Allocation	14,905
Management Company Allocation	3,709
TOTAL (agree to Schedule V, line 22, col.8)	\$ 365,707

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

Description	Line #	Amount
Section Not Applicable		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,990
Advertising: Employee Recruitment	610
Health Care Worker Background Check (Indicate # of checks performed 34)	1,020
Patient Background Checks 200	2,000
IHCA Dues	3,226
Miscellaneous Dues & Licenses	1,718
Home Office Allocation	605
Management Company Allocation	15
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,184

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	835
Seminar Expense	2,234
Management Company Allocation	696
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 3,765

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

HFS 3745 (N-4-99)

IL478-2471

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount. IHCA Dues \$3,226
- (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?

5-15 years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 1,277

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.

\$ 286,061

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.

\$ 560
- (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?

62%

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

TAYLORVILLE CARE CENTER, INC.
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII
12/31/2012

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 339,132
DEPRECIATION ADJUSTMENT	40,153
TRAVEL & ENTERTAINMENT ADJUSTMENT	2,064
CONVERSION TO CASH BASIS ADJUSTMENTS	(131,964)
POLITICAL CONTRIBUTIONS ADJUSTMENT	333
TAX NET INCOME	<u>\$ 249,718</u>

TAYLORVILLE CARE CENTER, INC.
IDPH ID #0028787
ATTACHMENT TO SCHEDULE XVII, LINE 28
12/31/2012

OTHER REVENUE:

MISCELLANEOUS ACTIVITIES DEPARTMENT INCOME	\$	260
COPY CHARGES - MEDICAL RECORDS		35
	\$	<u>295</u>

TAYLORVILLE CARE CENTER
ATTACHMENT TO SCHEDULE XIX, SECTION G
12/31/2012

NAME OF EMPLOYEE ATTENDING SEMINAR	JOB TITLE	DATE	LOCATION	SEMINAR TITLE	SEMINAR SPONSOR	SEMINAR COST
Kelly Walters	Care Plan Coordinator	03/27/12	Taylorville	Webinar - MDS 3.0: What's New? What's Not?	IHCA	15
Chantel Murphy	Director of Nursing	03/27/12	Taylorville	Webinar - MDS 3.0: What's New? What's Not?	IHCA	15
Erin Hogge	Care Plan Coordinator	03/27/12	Taylorville	Webinar - MDS 3.0: What's New? What's Not?	IHCA	15
Laurie Reatherford	MDS Coordinator	03/27/12	Taylorville	Webinar - MDS 3.0: What's New? What's Not?	IHCA	15
Rhonda Baker	Administrator	03/27/12	Taylorville	Webinar - MDS 3.0: What's New? What's Not?	IHCA	15
Rhonda Baker	Administrator	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Kelly Walters	Care Plan Coordinator	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Chantel Murphy	Director of Nursing	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Brenda Finfrock	Office Manager	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Terra Grafton	Activities	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Erin Hogge	Care Plan Coordinator	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Laurie Reatherford	MDS Coordinator	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Barb Taylor	Medical Records	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Kristie Green	Social Services	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Jan Steele	Housekeeping	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Tisha Baylor	Dietary	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Ashley Las	Therapy Aide	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Shelly Zeppin	Therapy Aide	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Amanda Cochlan	Housekeeping	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Shannon Gatton	CNA	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	40
Judy Funk	CNA	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	39
Jenni Stephens	Assistant Administrator	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	39
Candy Johnson	Dietary	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	39
Joy Durbin	Housekeeping	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	39
Bridget Acree	CNA	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA	39
Rhonda Baker	Administrator	10/08/12 - 10/10/12	Springfield	IL Pioneer Summit	IL Pioneer Coalition	186
Kelly Walters	Director of Nursing	10/08/12 - 10/10/12	Springfield	IL Pioneer Summit	IL Pioneer Coalition	186
Tisha Baylor	Dietary	10/08/12 - 10/10/12	Springfield	IL Pioneer Summit	IL Pioneer Coalition	186
Kristie Green	Social Services	10/08/12 - 10/10/12	Springfield	IL Pioneer Summit	IL Pioneer Coalition	186
Natalie Hurley	CNA	10/08/12 - 10/10/12	Springfield	IL Pioneer Summit	IL Pioneer Coalition	185
Dena Scoles	CNA	10/08/12 - 10/10/12	Springfield	IL Pioneer Summit	IL Pioneer Coalition	185

Rhonda Baker	Administrator	10/30/12 - 10/31/12	Springfield	INHAA Convention	INHAA	125
Kelly Walters	Director of Nursing	10/30/12 - 10/31/12	Springfield	INHAA Convention	INHAA	125
						2,234

Management Company Allocation

TRAVEL/
LODGING
COST

42
42
42
42
42
42
42
42
42
42
42
42
42
42
42
42
41
41
41
41
41

835
3,069
696
3,765

TAYLORVILLE CARE CENTER
IDPH# 0028787
ATTACHMENT TO SCHEDULE V
RECLASSIFICATION
12/31/2012

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20	\$ 4,204
SOCIAL SERVICES	12	65
ADMINISTRATIVE	17	(4,269)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISC. EXPENSE TO THE CORRECT LINES:		
BACKGROUND CHECKS	\$ 3,020	
DUES	49	
LICENSES & FEES	1,135	
SOCIAL SERVICES SUPPLIES	65	
TOTAL	<u>\$ 4,269</u>	
DIETARY	1	791
ACTIVITIES	11	(791)
TO RECLASS DIETARY CONSULTING FEES		
ADMINISTRATIVE	17	500
DIETARY	1	(500)
TO RECLASS ADMINISTRATIVE CONSULTING FEES		

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

<u>Name</u>	<u>Aviston Countryside Manor</u>	<u>Mt. Vernon Countryside Manor</u>	<u>Total Sch. VII C Column 5</u>
Jerry King	\$ 145,477	\$ 146,590	\$ 292,067
Denise King	112,056	112,913	224,969
Keith King	45,964	46,316	92,280
Marilyn King	1,921	1,935	3,856
Total	<u>\$ 305,418</u>	<u>\$ 307,754</u>	<u>\$ 613,172</u>