		FOR BHF USE					

LL1

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

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0028787

Facility Name: Taylorville Care Center, Inc.

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

County: Christian

Telephone Number: 217-824-9636 **Fax #** 217-824-8437

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amy Elik, Chief Financial Officer **Telephone Number:** 618-327-3064
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 01/01/2017 to 12/31/2017 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) Amy Elik
(Title) Chief Financial Officer

Paid Preparer
(Signed)
(Date)
(Print Name and Title) N/A
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,608	1,608	8
9	SNF/PED					9
10	ICF	13,702	9,090	459	23,251	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,702	9,090	2,067	24,859	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.50%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 24 and days of care provided 1,435

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	162,342	14,135	8,760	185,237		185,237		185,237			1
2	Food Purchase		142,625		142,625		142,625	(1,159)	141,466			2
3	Housekeeping	89,141	10,578		99,719		99,719		99,719			3
4	Laundry	60,171	14,670		74,841		74,841		74,841			4
5	Heat and Other Utilities			105,213	105,213		105,213	(6,178)	99,035			5
6	Maintenance	69,550	19,521	15,079	104,150		104,150	762	104,912			6
7	Other (specify):* Sanitation			4,031	4,031		4,031		4,031			7
8	**TOTAL General Services**	381,204	201,529	133,083	715,816		715,816	(6,575)	709,241			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,301,094	54,601	5,106	1,360,801		1,360,801	(134)	1,360,667			10
10a	Therapy											10a
11	Activities	37,795	4,586		42,381	2,687	45,068		45,068			11
12	Social Services	50,333	11	5,374	55,718	(2,687)	53,031		53,031			12
13	CNA Training											13
14	Program Transportation		3,947		3,947		3,947		3,947			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,389,222	63,145	20,080	1,472,447		1,472,447	(134)	1,472,313			16
	C. General Administration											
17	Administrative	82,943	4,816	290,000	377,759	(1,588)	376,171	(161,222)	214,949			17
18	Directors Fees											18
19	Professional Services			8,763	8,763	1,588	10,351	(2,361)	7,990			19
20	Dues, Fees, Subscriptions & Promotions			26,830	26,830		26,830	(15,822)	11,008			20
21	Clerical & General Office Expenses	30,238	9,539	62,426	102,203		102,203	70,263	172,466			21
22	Employee Benefits & Payroll Taxes			267,850	267,850		267,850	17,492	285,342			22
23	Inservice Training & Education			3,662	3,662	(1,296)	2,366		2,366			23
24	Travel and Seminar					1,596	1,596	169	1,765			24
25	Other Admin. Staff Transportation			1,016	1,016	(300)	716	338	1,054			25
26	Insurance-Prop.Liab.Malpractice			56,631	56,631		56,631	1,123	57,754			26
27	Other (specify):*											27
28	**TOTAL General Administration**	113,181	14,355	717,178	844,714		844,714	(90,020)	754,694			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,883,607	279,029	870,341	3,032,977		3,032,977	(96,729)	2,936,248			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Taylorville Care Center, Inc. #0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			78,026	78,026		78,026	4,387	82,413			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			48,612	48,612		48,612		48,612			33
34	Rent-Facility & Grounds							5,653	5,653			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			126,638	126,638		126,638	10,040	136,678			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,780	169,337	212,117		212,117	(571)	211,546			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			199,298	199,298		199,298		199,298			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		42,780	368,635	411,415		411,415	(571)	410,844			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,883,607	321,809	1,365,614	3,571,030		3,571,030	(87,260)	3,483,770			45

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

Taylorville Care Center, Inc.
Reclassifications
12/31/2017

Activities	Line 11	2,687
Social Services	Line 12	(2,687)

Reclass cost of activities consultant to correct line

Administrative	Line 17	(1,588)
Professional Services	Line 19	1,588

Reclass accounting fees to correct line

Travel & Seminar	Line 24	1,596
Inservice Training & Education	Line 23	(1,296)
Other Admin Staff Transportation	Line 25	(300)

Reclass seminar expenses to correct line

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(155)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,923)	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	306	30		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	(1,004)	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	(2,878)	17		19
20	Contributions	(1,230)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,897)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,882)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,859)	20		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,516)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,038)		$	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)	(54,222)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (54,222)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (87,260)		37

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

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

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

Taylorville Care Center, Inc.

ID# 0028787

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjust for 2017 IDPH license paid in 2016	$ 1,990	20	1
2	offset class action lawsuit settlement	(571)	39	2
3	offset medical records copies	(134)	10	3
4	eliminate chamber of commerce dues	(379)	20	4
5	eliminate IHCA lobbying amount	(1,846)	20	5
6	eliminate non-allowable travel	(576)	25	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**	(1,516)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,159)	0	0	0	0	0	0	0	0	0	0	(1,159)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,923)	745	0	0	0	0	0	0	0	0	0	(6,178)	5
6	Maintenance	0	762	0	0	0	0	0	0	0	0	0	762	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,082)	1,507	0	0	0	0	0	0	0	0	0	(6,575)	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	(134)	0	0	0	0	0	0	0	0	0	0	(134)	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**	(134)	0	0	0	0	0	0	0	0	0	0	(134)	16
	C. General Administration													
17	Administrative	(2,878)	(158,344)	0	0	0	0	0	0	0	0	0	(161,222)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,897)	2,536	0	0	0	0	0	0	0	0	0	(2,361)	19
20	Fees, Subscriptions & Promotions	(16,206)	384	0	0	0	0	0	0	0	0	0	(15,822)	20
21	Clerical & General Office Expenses	0	70,263	0	0	0	0	0	0	0	0	0	70,263	21
22	Employee Benefits & Payroll Taxes	0	17,492	0	0	0	0	0	0	0	0	0	17,492	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	169	0	0	0	0	0	0	0	0	0	169	24
25	Other Admin. Staff Transportation	(576)	914	0	0	0	0	0	0	0	0	0	338	25
26	Insurance-Prop.Liab.Malpractice	0	1,123	0	0	0	0	0	0	0	0	0	1,123	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(24,557)	(65,463)	0	0	0	0	0	0	0	0	0	(90,020)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,773)	(63,956)	0	0	0	0	0	0	0	0	0	(96,729)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Taylorville Care Center, Inc. **#** 0028787 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	306	4,081	0	0	0	0	0	0	0	0	0	4,387	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	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	5,653	0	0	0	0	0	0	0	0	0	5,653	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**	306	9,734	0	0	0	0	0	0	0	0	0	10,040	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(571)	0	0	0	0	0	0	0	0	0	0	(571)	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**	(571)	0	0	0	0	0	0	0	0	0	0	(571)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(33,038)	(54,222)	0	0	0	0	0	0	0	0	0	(87,260)	45

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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, IL	King Management Co.	O'Fallon, IL	Home Office
Leslie Pedtke 2011 Exempt Trust	20	Mt Vernon Countryside Manor, Inc.	Mt Vernon, IL	Residential Living Ctr	Mt Vernon, IL	Asstd Liv/MemCare
Keith King 2011 Exempt Trust	20			Taylorville Estates	Taylorville, IL	Assisted Living
Elizabeth Todorov 2011 Exempt Trust	20			Trenton Village	Trenton, IL	Asstd Liv/MemCare
Michelle Hirschfeld 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. [x] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	See Schedule VIII	$	King Management Company	0.00%	$ 745	$ 745	1
2	V	6	See Schedule VIII		King Management Company	0.00%	762	762	2
3	V	17	See Schedule VIII	290,000	King Management Company	0.00%	131,656	(158,344)	3
4	V	19	See Schedule VIII		King Management Company	0.00%	2,536	2,536	4
5	V	20	See Schedule VIII		King Management Company	0.00%	384	384	5
6	V	21	See Schedule VIII		King Management Company	0.00%	70,263	70,263	6
7	V	22	See Schedule VIII		King Management Company	0.00%	17,492	17,492	7
8	V	24	See Schedule VIII		King Management Company	0.00%	169	169	8
9	V	25	See Schedule VIII		King Management Company	0.00%	914	914	9
10	V	26	See Schedule VIII		King Management Company	0.00%	1,123	1,123	10
11	V	30	See Schedule VIII		King Management Company	0.00%	4,081	4,081	11
12	V	34	See Schedule VIII		King Management Company	0.00%	5,653	5,653	12
13	V								13
14	Total			$ 290,000			$ 235,778	$ * (54,222)	14

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Denise King	President	Administrative	20.00	200,048	10	25.00	Salary	$ 78,190	17,8	1
2	Leslie Pedtke	Corp. Educator	Administrative	20.00	136,596	10	25.00	Salary	53,389	17,8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 131,579		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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: King Management Company
Street Address: 1670 Essex Way Ste B
City / State / Zip Code: O'Fallon, IL 62269
Phone Number: (618-327-3064
Fax Number: (618-327-3083

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Accumulated Costs	13,278,553	6	$ 3,014	$	3,281,030	$ 745	1
2	6	Maintenance	Accumulated Costs	13,278,553	6	3,084		3,281,030	762	2
3	17	Administrative	Accumulated Costs	13,278,553	6	532,822	532,512	3,281,030	131,656	3
4	19	Professional Fees	Accumulated Costs	13,278,553	6	10,264		3,281,030	2,536	4
5	20	Dues, Fees & Subscriptions	Accumulated Costs	13,278,553	6	1,554		3,281,030	384	5
6	21	Clerical & Office Expense	Accumulated Costs	13,278,553	6	284,361	244,398	3,281,030	70,263	6
7	22	Emp Benefits & Payroll Taxes	Accumulated Costs	13,278,553	6	70,791		3,281,030	17,492	7
8	24	Travel & Seminar	Accumulated Costs	13,278,553	6	685		3,281,030	169	8
9	25	Other Administrative Transp.	Accumulated Costs	13,278,553	6	3,700		3,281,030	914	9
10	26	Insurance	Accumulated Costs	13,278,553	6	4,543		3,281,030	1,123	10
11	30	Depreciation	Accumulated Costs	13,278,553	6	16,517		3,281,030	4,081	11
12	34	Rent-Facility & Grounds	Accumulated Costs	13,278,553	6	22,880		3,281,030	5,653	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					$ 954,215	$ 776,910		$ 235,778	25

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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. $ None Line # N/A

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

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 50,000	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.)		$ 48,612	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,388)	3
4. Real Estate Tax accrual used for 2017 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.		$ 48,612	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	47,277	8
	2013	47,853	9
	2014	48,095	10
	2015	48,613	11
	2016	48,612	12

Line 4: Based on 2016 taxes paid plus inflationary increase.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Taylorville Care Center, Inc. COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0028787

CONTACT PERSON REGARDING THIS REPORT Amy Elik

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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-13-28-401-005-00	Cheneys Add Lts1 thru 6 Blk 3	$ 48,611.74	$ 48,611.74
2.		& Lts1 thru 6 Blk 4 & OL 1 &	$	$
3.		Vac Austin St & Alley	$	$
4.		282x652 13-28-G	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 48,611.74	$ 48,611.74

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,610 B. General Construction Type: Exterior Brick Frame Non-Comb Sprinkle Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

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

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	98 bed nursing home	186,200	1984	$ 40,000	1
2					2
3	TOTALS	186,200		$ 40,000	3

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1984	1974	$ 1,560,000	$	25	$	$	$ 1,560,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	80 Gallon Water Fixture			1985	1,581		10			1,581	9
10	Improvements to Building			1985	12,510		25			12,510	10
11	Improvements to Parking Lot			1986	1,184		10			1,184	11
12	New Light Fixtures			1987	997		10			997	12
13	Tile Floor			1987	5,941		10			5,941	13
14	Roof			1988	55,100		10			55,100	14
15	Addition to Alarm System			1988	5,610		10			5,610	15
16	Concrete Driveway			1989	2,729		15			2,729	16
17	Nurse's Station			1991	4,809		15			4,809	17
18	Air Conditioner			1993	2,800		10			2,800	18
19	New Office			1993	1,500	37	40	37		900	19
20	4 Inch Backflow Preventer			1994	3,966	159	40	159		3,807	20
21	Carpeting			1994	2,471		25			2,471	21
22	Fence			1995	3,590		15			3,590	22
23	Sprinkler Heads			1995	1,600		15			1,600	23
24	New Roof			1996	25,000		10			25,000	24
25	Ceramic Tile			1997	5,167		10			5,167	25
26	Garage			1997	7,841		10			7,841	26
27	Rooftop A/C, Ducts and Gas Lines			1997	10,940		10			10,940	27
28	Beauty Shop Addition			1997	6,823		15			6,823	28
29	Carpeting			1998	4,154		10			4,154	29
30	Heating and A/C Units			1998	4,128		5			4,128	30
31	Air Conditioner Units			1999	25,051		10			25,051	31
32	Rear Parking Lot/Driveway			1999	2,996		10			2,996	32
33	Air Conditioner Units			2000	4,834		10			4,834	33
34	Landscaping			2001	2,300		10			2,300	34
35	Electrical			2001	6,725		10			6,725	35
36	Cabinets			2001	27,444	1,372	20	1,372		22,985	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Wallpaper & Installation	2002	$ 9,016	$	5	$	$	$ 9,016	37
38	Wallguards	2002	5,729	95	15	95		5,729	38
39	Water Heater	2002	6,759	338	15	338		6,759	39
40	Carpet/Baseboard Remodel	2002	16,561		10			16,561	40
41	Landscaping	2004	5,106		10			5,106	41
42	20' Gazebo	2004	24,761	1,651	15	1,651		21,872	42
43	Parking Lot	2004	27,200		8			27,200	43
44	Lawn Sprinkler System	2004	3,850	257	15	257		3,422	44
45	Landscaping	2004	8,977		10			8,977	45
46	Vinyl Fence	2004	5,219		10			5,219	46
47	Facility Sign	2004	2,632		10			2,632	47
48	100 Gallon Water Heater	2004	2,390		10			2,390	48
49	Sidewalk	2004	1,920	128	15	128		1,707	49
50	Telephone System	2004	4,337		10			4,337	50
51	Concrete Sidewalk	2005	3,100	207	15	207		2,532	51
52	Storage Building	2006	4,030	202	20	202		2,233	52
53	Fire System Upgrade	2007	5,577	46	7		(46)	5,577	53
54	Carpet	2007	31,573		5			31,573	54
55	Wallpaper	2007	43,285		5			43,285	55
56	Wallpaper	2007	17,086		5			17,086	56
57	Rooftop Vents	2007	2,309		10			2,309	57
58	Sidewalk	2007	6,785	339	15	452	113	4,523	58
59	Water Softener System	2010	4,700	470	10	470		3,408	59
60	Tile Flooring	2010	2,244	224	10	224		1,646	60
61	Plumbing Upgrades	2010	21,525	1,076	20	1,076		8,431	61
62	Ceramic Tile	2010	15,575	779	20	779		5,516	62
63	Vinyl Tile	2010	1,320	132	10	132		924	63
64	Ceramic Tile	2010	32,565	1,628	20	1,628		11,669	64
65	Light Fixtures	2011	2,423	242	10	242		1,575	65
66	Cabinetry & Built-In Desk for Therapy	2011	5,898	393	15	393		2,588	66
67	Roof	2011	50,303	3,354	15	3,354		21,518	67
68	Cherry Flooring	2011	14,258	1,426	10	1,426		8,911	68
69	Shower Room Tile	2011	3,477	232	15	232		1,487	69
70	TOTAL (lines 4 thru 69)		$ 2,192,281	$ 14,787		$ 14,854	$ 67	$ 2,092,291	70

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,192,281	$ 14,787		$ 14,854	$ 67	$ 2,092,291	1
2	Flat Roof	2011	11,269	1,127	10	1,127		7,137	2
3	Roof & Parapet Wall	2011	51,757	3,450	15	3,450		20,703	3
4	Wallpaper & Border	2011	8,393		5			8,393	4
5	Tile Flooring Installation	2011	10,000	1,000	10	1,000		6,083	5
6	Custom Nurses' Station	2011	27,690	1,846	15	1,846		11,230	6
7	Hand Rail & Crash Rail	2011	8,946	596	15	596		3,628	7
8	Water Heater	2012	4,114	411	10	411		2,434	8
9	Walk-In Cooler Condensing Unit	2012	2,774	185	15	185		1,002	9
10	Building Generator	2013	51,847	2,592	20	2,592		10,802	10
11	Gazebo	2013	1,257	84	15	84		363	11
12	Concrete Drive	2013	12,954	864	15	864		3,958	12
13	Concrete Dumpster Pad & Walk	2013	3,700	247	15	247		1,069	13
14	Cabinets & Countertop	2013	3,010	201	15	201		803	14
15	Rooftop A/C System - 5-ton	2013	5,288	529	10	529		2,115	15
16	Paint Ceilings in A & C	2014	11,643	2,329	5	2,329		9,120	16
17	Paint Ceilings in Main Hallway	2014	2,800	560	5	560		2,147	17
18	Paint Ceilings in 15 Rooms	2014	9,000	1,800	5	1,800		6,150	18
19	Hallway Lighting	2014	2,080	208	10	208		780	19
20	Fitness Room Lighting	2014	2,430	243	10	243		891	20
21	5-ton Roof-Top HVAC	2014	5,352	357	15	357		1,100	21
22	Cable Wiring A Hall	2014	2,600	144	18	144		494	22
23	100 Gal Water Heater	2015	5,157	516	10	516		1,246	23
24	New Steel Service Door & Frame	2015	8,268	413	20	413		861	24
25	Concrete Work	2015	3,650	243	15	243		547	25
26	Additional 2011 Assets			616			(616)		26
27	Drywall & Painting-A,B & C Wing hallways	2016	11,740	783	15	783		1,565	27
28	Water Heater	2016	5,897	590	10	590		934	28
29	5 Ton Gas/Electric Rooftop HVAC	2016	5,582	558	10	558		605	29
30	New Windows Entire Facility	2016	93,937	4,697	20	4,697		5,088	30
31	Rewiring for TV system	2017	5,400	158	39	87	(71)	87	31
32	Interior Signage	2017	2,552	213	7	364	151	365	32
33	4 PTAC Units	2017	3,166	211	7	452	241	452	33
34	TOTAL (lines 1 thru 33)		$ 2,576,534	$ 42,558		$ 42,330	$ (228)	$ 2,204,443	34

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,576,534	$ 42,558		$ 42,330	$ (228)	$ 2,204,443	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,576,534	$ 42,558		$ 42,330	$ (228)	$ 2,204,443	34

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 222,458	$ 17,973	$ 20,344	$ 2,371	3-20	$ 104,059	71
72	Current Year Purchases	14,301	1,277	2,043	766	7	2,043	72
73	Fully Depreciated Assets	299,784	6,215	6,235	20	3-20	299,784	73
74								74
75	TOTALS	$ 536,543	$ 25,465	$ 28,622	$ 3,157		$ 405,886	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	2013 Ford E450 Bus	2016	$ 40,015	$ 10,003	$ 10,003	$	4	$ 15,006	76
77	Home Office Vehicle	2017 Porsche Cayenne	2017	17,500		1,458	1,458	4	1,458	77
78										78
79										79
80	TOTALS			$ 57,515	$ 10,003	$ 11,461	$ 1,458		$ 16,464	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)	$ 3,210,592	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 78,026	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 82,413	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,387	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,626,793	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section N/A

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: ☒ N/A ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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	Section N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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				42,706		42,706	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Therapy	39,3				160,177			160,177	12
13	Other (specify): Lab,Xray,Ambul,Supp	39,2 & 39,3				8,589	74		8,663	13
14	TOTAL			$		$ 168,766	$ 42,780		$ 211,546	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.

STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 479,037	$	1
2	Cash-Patient Deposits	8,274		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 60,000)	614,505		3
4	Supply Inventory (priced at cost)	6,072		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,837		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)**	$ 1,111,725	$	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	2,551,363		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	555,168		16
17	Accumulated Depreciation (book methods)	(2,588,780)		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)**	$ 557,751	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,669,476	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 33,404	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,274		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,484		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,623		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	Accrued Provider Taxes	23,970		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 281,755	$	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)**	$ 281,755	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,387,721	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,669,476	$	48

***(See instructions.)**

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,668,577	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,668,577	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	196,294	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	(1,477,150)	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)**	$ (1,280,856)	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)**	$ 1,387,721	24 *

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,429,225	1
2	Discounts and Allowances for all Levels	(1,205,535)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,223,690	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	532,850	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 532,850	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	155	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	3,681	19
20	Radiology and X-Ray	2,516	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,352	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,267	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,267	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	571	27
28	Medical Records copies	134	28
28a	Vending Machine commission	460	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,165	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,767,324	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	715,816	31
32	Health Care	1,472,447	32
33	General Administration	844,714	33
	B. Capital Expense		
34	Ownership	126,638	34
	C. Ancillary Expense		
35	Special Cost Centers	212,117	35
36	Provider Participation Fee	199,298	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,571,030	40
41	**Income before Income Taxes (line 30 minus line 40)****	196,294	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 196,294	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,160,621	44
45	Private Pay - Net Inpatient Revenue	798,928	45
46	Medicare - Net Inpatient Revenue	264,141	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,223,690	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

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

TAYLORVILLE CARE CENTER, INC.
Book to Tax Income Reconciliation
ATTACHMENT TO SCHEDULE XVII
12/31/2017

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	$	196,294
DEPRECIATION ADJUSTMENT		33,328
CONVERSION TO CASH BASIS ADJUSTMENTS		822,876
OTHER MISC BOOK TO TAX ADJUSTMENTS		8,593
TAX NET INCOME	$	1,061,091

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,125	2,271	$ 73,426	$ 32.33	1
2	Assistant Director of Nursing	1,951	2,149	49,399	22.99	2
3	Registered Nurses	2,521	2,500	56,992	22.80	3
4	Licensed Practical Nurses	19,838	20,639	383,117	18.56	4
5	CNAs & Orderlies	52,598	53,521	600,903	11.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,212	2,356	34,067	14.46	8
9	Activity Director	1,799	1,905	20,349	10.68	9
10	Activity Assistants	1,872	1,920	17,446	9.09	10
11	Social Service Workers	4,332	4,429	50,333	11.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,235	16,882	162,342	9.62	15
16	Dishwashers					16
17	Maintenance Workers	4,289	4,470	69,550	15.56	17
18	Housekeepers	9,265	9,705	89,141	9.19	18
19	Laundry	5,426	5,885	60,171	10.22	19
20	Administrator	1,875	2,059	82,943	40.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,958	2,127	30,238	14.22	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	1,464	1,587	17,049	10.74	31
32	Other Health C: MDS/CarePlans	3,762	4,172	86,141	20.65	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,522	138,577	$ 1,883,607 *	$ 13.59	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	144	$ 8,079	1,3	35
36	Medical Director	contract	9,600	9,3	36
37	Medical Records Consultant	34	2,700	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	contract	2,406	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	36	2,687	11,3	44
45	Social Service Consultant	36	2,687	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	250	$ 28,159		49

C. CONTRACT NURSES

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rhonda Hancock	Administrator	0	$ 82,943
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,943

B. Administrative - Other

Description	Amount
Management Fee-King Management Company	$ 290,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 290,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mathis, Marifian & Richter,Ltd	Legal/Collections	$ 4,897
C.J. Schlosser & Company, LLC	Accounting	3,866
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 8,763

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,489
Unemployment Compensation Insurance	38,310
FICA Taxes	141,877
Employee Health Insurance	31,344
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,752
Pension Expense-Employer Contribution	911
Employee Uniforms	3,167
Home Office Allocation	17,492
TOTAL (agree to Schedule V, line 22, col.8)	$ 285,342

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,269
Health Care Worker Background Check	650
(Indicate # of checks performed 65)	
Fingerprinting	1,160
Miscellaneous Dues & Licenses	1,256
IHCA Dues	4,299
Home Office Allocation	384
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,008

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	300
Seminar Expense	1,296
Home Office Allocation	169
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,765

* Attach copy of IMRF notifications

**See instructions.

TAYLORVILLE CARE CENTER, INC.
Legal Fees
ATTACHMENT TO SCHEDULE XIX-C
12/31/2017

Invoice Date	Law Firm Name	Allowable/Non-allowable	Amount	Description
1/31/2017	Mathis, Marifian & Richter, Ltd	Non-allowable	2,257.00	Patient account collections
2/28/2017	Mathis, Marifian & Richter, Ltd	Non-allowable	480.00	Patient account collections
3/31/2017	Mathis, Marifian & Richter, Ltd	Non-allowable	820.00	Patient account collections
4/30/2017	Mathis, Marifian & Richter, Ltd	Non-allowable	140.00	Patient account collections
5/31/2017	Mathis, Marifian & Richter, Ltd	Non-allowable	120.00	Patient account collections
8/31/2017	Mathis, Marifian & Richter, Ltd	Non-allowable	240.00	Patient account collections
9/30/2017	Mathis, Marifian & Richter, Ltd	Non-allowable	240.00	Patient account collections/retainer
11/30/2017	Mathis, Marifian & Richter, Ltd	Non-allowable	60.00	retainer
12/31/2017	Mathis, Marifian & Richter, Ltd	Non-allowable	540.00	retainer
			4,897.00	all are non-allowable

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. **Illinois Health Care Association $4,299**

(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? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **987** 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. $ **199,298**
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. $ **155**

(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? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

(19) 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