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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 01/01/2018 to 12/31/2018 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)

(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: 01/01/2018 Ending: 12/31/2018

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			1,935	1,935	8
9	SNF/PED					9
10	ICF	16,077	7,856	602	24,535	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,077	7,856	2,537	26,470	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.00%

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 1,753

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	161,947	15,480	8,776	186,203		186,203		186,203			1
2	Food Purchase		156,661		156,661		156,661	(1,365)	155,296			2
3	Housekeeping	106,253	9,432		115,685		115,685	4	115,689			3
4	Laundry	61,193	14,544		75,737		75,737		75,737			4
5	Heat and Other Utilities			118,146	118,146		118,146	(7,765)	110,381			5
6	Maintenance	71,127	33,014	21,881	126,022		126,022	698	126,720			6
7	Other (specify):* Sanitation			4,300	4,300		4,300	(799)	3,501			7
8	**TOTAL General Services**	400,520	229,131	153,103	782,754		782,754	(9,227)	773,527			8
	B. Health Care and Programs											
9	Medical Director			8,800	8,800		8,800		8,800			9
10	Nursing and Medical Records	1,434,045	73,899	71,360	1,579,304		1,579,304	(175)	1,579,129			10
10a	Therapy											10a
11	Activities	46,644	5,590		52,234	2,560	54,794		54,794			11
12	Social Services	41,273		5,119	46,392	(2,560)	43,832		43,832			12
13	CNA Training											13
14	Program Transportation		4,015		4,015		4,015		4,015			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,521,962	83,504	85,279	1,690,745		1,690,745	(175)	1,690,570			16
	C. General Administration											
17	Administrative	86,428	6,239	332,000	424,667	(3,796)	420,871	(176,346)	244,525			17
18	Directors Fees											18
19	Professional Services			9,170	9,170	3,796	12,966	(2,055)	10,911			19
20	Dues, Fees, Subscriptions & Promotions			43,588	43,588		43,588	(27,385)	16,203			20
21	Clerical & General Office Expenses	30,527	11,210	61,695	103,432		103,432	74,130	177,562			21
22	Employee Benefits & Payroll Taxes			274,344	274,344	150	274,494	14,369	288,863			22
23	Inservice Training & Education			4,440	4,440	(1,170)	3,270		3,270			23
24	Travel and Seminar					1,020	1,020	345	1,365			24
25	Other Admin. Staff Transportation			444	444		444	1,261	1,705			25
26	Insurance-Prop.Liab.Malpractice			43,055	43,055		43,055	843	43,898			26
27	Other (specify):*											27
28	**TOTAL General Administration**	116,955	17,449	768,736	903,140		903,140	(114,838)	788,302			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,039,437	330,084	1,007,118	3,376,639		3,376,639	(124,240)	3,252,399			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: 01/01/2018 Ending: 12/31/2018

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			74,947	74,947		74,947	7,661	82,608			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			58,427	58,427		58,427		58,427			33
34	Rent-Facility & Grounds							5,392	5,392			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			133,374	133,374		133,374	13,053	146,427			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,907	251,848	316,755		316,755	(41)	316,714			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			198,795	198,795		198,795		198,795			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		64,907	450,643	515,550		515,550	(41)	515,509			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,039,437	394,991	1,591,135	4,025,563		4,025,563	(111,228)	3,914,335			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
12/31/2018

Activities	Line 11	2,560
Social Services	Line 12	(2,560)

Reclass cost of activities consultant to correct line

Administrative	Line 17	(3,796)
Professional Services	Line 19	3,796

Reclass accounting fees to correct line

Employee Benefits & Payroll Taxes	Line 22	150
Travel & Seminar	Line 24	1,020
Inservice Training & Education	Line 23	(1,170)

Reclass seminar & tuition expenses to correct lines

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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				4
5	Telephone, TV & Radio in Resident Rooms	(8,580)	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	758	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	(1,365)	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	(4,290)	20		18
19	Entertainment	(2,193)	17		19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,131)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,786)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(15,751)	20		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,721)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (46,159)		$	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)	(65,069)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (65,069)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (111,228)		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: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	offset class action lawsuit settlement	$ (41)	39	1
2	offset class action lawsuit settlement	(799)	7	2
3	offset employee flu vaccine income	(175)	10	3
4	eliminate chamber of commerce dues	(758)	20	4
5	eliminate lobbying portion of IHCA dues	(1,958)	20	5
6	eliminate 2019 IDPH license fee paid in 2018	(1,990)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,721)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(1,365)	0	0	0	0	0	0	0	0	0	0	(1,365)	2
3	Housekeeping	0	4	0	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(8,580)	815	0	0	0	0	0	0	0	0	0	(7,765)	5
6	Maintenance	0	698	0	0	0	0	0	0	0	0	0	698	6
7	Other (specify):*	(799)	0	0	0	0	0	0	0	0	0	0	(799)	7
8	**TOTAL General Services**	(10,744)	1,517	0	0	0	0	0	0	0	0	0	(9,227)	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	(175)	0	0	0	0	0	0	0	0	0	0	(175)	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**	(175)	0	0	0	0	0	0	0	0	0	0	(175)	16
	C. General Administration													
17	Administrative	(2,193)	(174,153)	0	0	0	0	0	0	0	0	0	(176,346)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,131)	4,076	0	0	0	0	0	0	0	0	0	(2,055)	19
20	Fees, Subscriptions & Promotions	(27,633)	248	0	0	0	0	0	0	0	0	0	(27,385)	20
21	Clerical & General Office Expenses	0	74,130	0	0	0	0	0	0	0	0	0	74,130	21
22	Employee Benefits & Payroll Taxes	0	14,369	0	0	0	0	0	0	0	0	0	14,369	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	345	0	0	0	0	0	0	0	0	0	345	24
25	Other Admin. Staff Transportation	0	1,261	0	0	0	0	0	0	0	0	0	1,261	25
26	Insurance-Prop.Liab.Malpractice	0	843	0	0	0	0	0	0	0	0	0	843	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(35,957)	(78,881)	0	0	0	0	0	0	0	0	0	(114,838)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(46,876)	(77,364)	0	0	0	0	0	0	0	0	0	(124,240)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 **Report Period Beginning:** 01/01/2018 **Ending:** 12/31/2018

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	758	6,903	0	0	0	0	0	0	0	0	0	7,661	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	5,392	0	0	0	0	0	0	0	0	0	5,392	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**	758	12,295	0	0	0	0	0	0	0	0	0	13,053	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	(41)	0	0	0	0	0	0	0	0	0	0	(41)	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**	(41)	0	0	0	0	0	0	0	0	0	0	(41)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(46,159)	(65,069)	0	0	0	0	0	0	0	0	0	(111,228)	45

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	3	See Schedule VIII	$	King Management Company	0.00%	$ 4	$ 4	1
2	V	5	See Schedule VIII		King Management Company	0.00%	815	815	2
3	V	6	See Schedule VIII		King Management Company	0.00%	698	698	3
4	V	17	See Schedule VIII	332,000	King Management Company	0.00%	157,847	(174,153)	4
5	V	19	See Schedule VIII		King Management Company	0.00%	4,076	4,076	5
6	V	20	See Schedule VIII		King Management Company	0.00%	248	248	6
7	V	21	See Schedule VIII		King Management Company	0.00%	74,130	74,130	7
8	V	22	See Schedule VIII		King Management Company	0.00%	14,369	14,369	8
9	V	24	See Schedule VIII		King Management Company	0.00%	345	345	9
10	V	25	See Schedule VIII		King Management Company	0.00%	1,261	1,261	10
11	V	26	See Schedule VIII		King Management Company	0.00%	843	843	11
12	V	30	See Schedule VIII		King Management Company	0.00%	6,903	6,903	12
13	V	34	See Schedule VIII		King Management Company	0.00%	5,392	5,392	13
14	Total			$ 332,000			$ 266,931	$ * (65,069)	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: 01/01/2018 Ending: 12/31/2018

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	186,137	9	24.00	Salary	$ 80,888	17,8	1
2	Leslie Pedtke	Corp. Educator	Administrative	20.00	175,258	9	24.00	Salary	76,161	17,8	2
3	Keith King			20.00	950	1	24.00	Salary	413	17,8	3
4	Elizabeth King			20.00	832	1	24.00	Salary	361	17,8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 157,823		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: 01/01/2018 Ending: 2/31/2018

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	3	Housekeeping	Accumulated Costs	15,673,161	6	$ 18	$	3,693,563	$ 4	1
2	5	Heat & Other Utilities	Accumulated Costs	15,673,161	6	3,457		3,693,563	815	2
3	6	Maintenance	Accumulated Costs	15,673,161	6	2,960		3,693,563	698	3
4	17	Administrative	Accumulated Costs	15,673,161	6	669,802	669,702	3,693,563	157,847	4
5	19	Professional Services	Accumulated Costs	15,673,161	6	17,295		3,693,563	4,076	5
6	20	Dues, Fees, Subscriptions & Prom	Accumulated Costs	15,673,161	6	1,054		3,693,563	248	6
7	21	Clerical & General Office Expens	Accumulated Costs	15,673,161	6	314,561	277,254	3,693,563	74,130	7
8	22	Employee Benefits & Payroll Taxe	Accumulated Costs	15,673,161	6	60,971		3,693,563	14,369	8
9	24	Travel & Seminar	Accumulated Costs	15,673,161	6	1,466		3,693,563	345	9
10	25	Other Admin Staff Transportatior	Accumulated Costs	15,673,161	6	5,353		3,693,563	1,261	10
11	26	Insurance-Prop,Liab, Malpractice	Accumulated Costs	15,673,161	6	3,577		3,693,563	843	11
12	30	Depreciation	Accumulated Costs	15,673,161	6	29,292		3,693,563	6,903	12
13	34	Rent-Facility & Grounds	Accumulated Costs	15,673,161	6	22,880		3,693,563	5,392	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					$ 1,132,686	$ 946,956		$ 266,931	25

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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. $ 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: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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.)		$ 53,677	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,677	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 54,750	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.		$ 58,427	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	47,853	8
	2014	48,095	9
	2015	48,613	10
	2016	48,612	11
	2017	53,677	12

Line 4: Based on 2017 taxes paid plus an inflationary increase.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-13-28-401-005-00	Cheney's Add Lts 1-6 Blk 3 &	$ 53,677.30	$ 53,677.30
2.		Lts 1-6 Blk4 & OL 1 & Vac	$	$
3.		Austin St & Alley	$	$
4.		282x652 13-28-G	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 53,677.30	$ 53,677.30

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 01/01/2018 Ending: 12/31/2018

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, Inc.

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: 01/01/2018 Ending: 12/31/2018

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 Heater			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		937	19
20	4 Inch Backflow Preventer			1994	3,966	159	25	159		3,966	20
21	Carpeting			1994	2,471		10			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-disposed in 2018			1997			10				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		24,357	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: 01/01/2018 Ending: 12/31/2018

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		15			5,729	38
39	Water Heater	2002	6,759		15			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		23,523	42
43	Parking Lot	2004	27,200		8			27,200	43
44	Lawn Sprinkler System	2004	3,850	257	15	257		3,679	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		1,835	49
50	Telephone System	2004	4,337		10			4,337	50
51	Concrete Sidewalk	2005	3,100	207	15	207		2,738	51
52	Storage Building	2006	4,030	202	20	202		2,435	52
53	Fire System Upgrade	2007	5,577		7			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	4,976	58
59	Water Softener System	2010	4,700	470	10	470		3,878	59
60	Tile Flooring	2010	2,244	224	10	224		1,870	60
61	Plumbing Upgrades	2010	21,525	1,076	20	1,076		9,507	61
62	Ceramic Tile	2010	15,575	779	20	779		6,295	62
63	Vinyl Tile	2010	1,320	132	10	132		1,056	63
64	Ceramic Tile	2010	32,565	1,628	20	1,628		13,297	64
65	Light Fixtures	2011	2,423	242	10	242		1,817	65
66	Cabinetry & Built-In Desk for Therapy	2011	5,898	393	15	393		2,981	66
67	Roof	2011	50,303	3,354	15	3,354		24,872	67
68	Cherry Flooring	2011	14,258	1,426	10	1,426		10,337	68
69	Shower Room Tile	2011	3,477	232	15	232		1,719	69
70	TOTAL (lines 4 thru 69)		$ 2,181,341	$ 14,308		$ 14,421	$ 113	$ 2,095,772	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: 01/01/2018 Ending: 12/31/2018

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		$ 2,181,341	$ 14,308		$ 14,421	$ 113	$ 2,095,772	1
2	Flat Roof	2011	11,269	1,127	10	1,127		8,264	2
3	Roof & Parapet Wall	2011	51,757	3,450	15	3,450		24,153	3
4	Wallpaper & Border	2011	8,393		5			8,393	4
5	Tile Flooring Installation	2011	10,000	1,000	10	1,000		7,083	5
6	Custom Nurses' Station	2011	27,690	1,846	15	1,846		13,076	6
7	Hand Rail & Crash Rail	2011	8,946	596	15	596		4,225	7
8	Water Heater	2012	4,114	411	10	411		2,845	8
9	Walk-In Cooler Condensing Unit	2012	2,774	185	15	185		1,187	9
10	Building Generator	2013	51,847	2,592	20	2,592		13,394	10
11	Gazebo	2013	1,257	84	15	84		447	11
12	Concrete Drive	2013	12,954	864	15	864		4,822	12
13	Concrete Dumpster Pad & Walk	2013	3,700	247	15	247		1,316	13
14	Cabinets & Countertop	2013	3,010	201	15	201		1,003	14
15	Rooftop A/C System - 5-ton	2013	5,288	529	10	529		2,644	15
16	Paint Ceilings in A & C	2014	11,643	2,329	5	2,329		11,449	16
17	Paint Ceilings in Main Hallway	2014	2,800	560	5	560		2,707	17
18	Paint Ceilings in 15 Rooms	2014	9,000	1,800	5	1,800		7,950	18
19	Hallway Lighting	2014	2,080	208	10	208		988	19
20	Fitness Room Lighting	2014	2,430	243	10	243		1,134	20
21	5-ton Roof-Top HVAC	2014	5,352	357	15	357		1,457	21
22	Cable Wiring A Hall	2014	2,600	144	18	144		638	22
23	100 Gal Water Heater	2015	5,157	516	10	516		1,762	23
24	New Steel Service Door & Frame	2015	8,268	413	20	413		1,275	24
25	Concrete Work	2015	3,650	243	15	243		791	25
26	Additional 2011 Assets			616			(616)		26
27	Drywall & Painting-A,B & C Wing hallways	2016	11,740	783	15	783		2,348	27
28	Water Heater	2016	5,897	590	10	590		1,523	28
29	5 Ton Gas/Electric Rooftop HVAC	2016	5,582	558	10	558		1,163	29
30	New Windows Entire Facility	2016	93,937	4,697	20	4,697		9,785	30
31	Rewiring for TV system	2017	5,400	270	39	138	(132)	225	31
32	Interior Signage	2017	2,552	510	7	625	115	989	32
33	4 PTAC Units	2017	3,166	633	7	775	142	1,228	33
34	TOTAL (lines 1 thru 33)		$ 2,565,594	$ 42,910		$ 42,532	$ (378)	$ 2,236,036	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: 01/01/2018 Ending: 12/31/2018

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		$ 2,565,594	$ 42,910		$ 42,532	$ (378)	$ 2,236,036	1
2	Insulation in Attic for Sprinkler System	2018	9,620	353	25	353		353	2
3	Carrier 5 Ton Rooftop AC Unit	2018	5,805	580	10	580		580	3
4	Wanderguard Blue System	2018	5,064	422	10	422		422	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,586,083	$ 44,265		$ 43,887	$ (378)	$ 2,237,391	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: 01/01/2018 Ending: 12/31/2018

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	$ 228,663	$ 19,117	$ 22,234	$ 3,117	3-20	$ 121,453	71
72	Current Year Purchases	28,057	1,313	1,313		5-10	1,313	72
73	Fully Depreciated Assets	304,111	248	650	402	3-20	304,111	73
74								74
75	TOTALS	$ 560,831	$ 20,678	$ 24,197	$ 3,519		$ 426,877	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	$ 10,004	$ 10,004	$	4	$ 25,009	76
77	Home Office Vehicle	2017 Porsche Cayenne	2017	16,690		4,520	4,520	4	5,911	77
78										78
79										79
80	TOTALS			$ 56,705	$ 10,004	$ 14,524	$ 4,520		$ 30,920	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)	$ 3,243,619	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 74,947	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 82,608	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,661	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,695,188	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: 01/01/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: 01/01/2018 Ending: 12/31/2018

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
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				59,447		59,447	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Therapy	39,3				229,532			229,532	12
13	Other (specify): Lab,Xray,Ambul,Supp	39,2&39,3				22,275	5,460		27,735	13
14	TOTAL			$		$ 251,807	$ 64,907		$ 316,714	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: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 658,379	$	1
2	Cash-Patient Deposits	12,639		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 38,959)	535,748		3
4	Supply Inventory (priced at cost)	6,072		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,951		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)**	$ 1,215,789	$	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	2,560,912		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	579,983		16
17	Accumulated Depreciation (book methods)	(2,649,971)		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)**	$ 530,924	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,746,713	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 61,146	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,639		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	173,872		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,873		31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,750		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 313,280	$	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)**	$ 313,280	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,433,433	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,746,713	$	48

*(See instructions.)

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,387,721	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,387,721	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	470,712	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	(425,000)	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)**	$ 45,712	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)**	$ 1,433,433	24 *

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

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 4,891,316	1
2	Discounts and Allowances for all Levels	(1,079,566)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,811,750	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	655,886	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 655,886	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		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	15,270	19
20	Radiology and X-Ray	4,102	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 19,372	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,751	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,751	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	840	27
28	Gain on Sale of Asset	1,500	28
28a	Other Revenue	176	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,516	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,496,275	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	782,754	31
32	Health Care	1,690,745	32
33	General Administration	903,140	33
	B. Capital Expense		
34	Ownership	133,374	34
	C. Ancillary Expense		
35	Special Cost Centers	316,755	35
36	Provider Participation Fee	198,795	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,025,563	40
41	**Income before Income Taxes (line 30 minus line 40)****	470,712	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 470,712	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,319,400	44
45	Private Pay - Net Inpatient Revenue	1,176,008	45
46	Medicare - Net Inpatient Revenue	316,342	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,811,750	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
12/31/2018

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	$	470,712
DEPRECIATION ADJUSTMENT		18,421
CONVERSION TO CASH BASIS ADJUSTMENTS		106,804
OTHER MISC BOOK TO TAX ADJUSTMENTS		29,470
TAX NET INCOME	$	625,407

TAYLORVILLE CARE CENTER, INC.
Detail of Other Revenue
ATTACHMENT TO SCHEDULE XVII
12/31/2018

Class action lawsuit settlement	41	offset to ln 39
Class action lawsuit settlement	799	offset to ln 7
Gain on sale of asset	1,500	
Employee flu vaccine income	175	offset to ln 10
Other miscellaneous income	1	
	2,516	

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	2,224	2,490	$ 82,999	$ 33.33	1
2	Assistant Director of Nursing	2,227	2,419	60,975	25.21	2
3	Registered Nurses	1,846	1,871	49,825	26.63	3
4	Licensed Practical Nurses	17,280	17,909	363,597	20.30	4
5	CNAs & Orderlies	55,975	57,864	720,568	12.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,357	2,521	40,376	16.02	8
9	Activity Director	1,907	2,034	23,759	11.68	9
10	Activity Assistants	2,451	2,491	22,885	9.19	10
11	Social Service Workers	3,248	3,342	41,273	12.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,815	16,431	161,947	9.86	15
16	Dishwashers					16
17	Maintenance Workers	3,852	4,140	71,127	17.18	17
18	Housekeepers	11,123	11,607	106,253	9.15	18
19	Laundry	5,369	5,753	61,193	10.64	19
20	Administrator	1,926	2,111	86,428	40.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,993	2,099	30,527	14.54	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	1,401	1,516	17,508	11.55	31
32	Other Health C: MDS/CarePlan	3,924	4,367	98,197	22.49	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,918	140,965	$ 2,039,437 *	$ 14.47	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	$ 8,398	1,3	35
36	Medical Director	contract	8,800	9,3	36
37	Medical Records Consultant	39	2,900	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	contract	2,616	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	34	2,560	11,3	44
45	Social Service Consultant	34	2,559	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	251	$ 27,833		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,968	65,844	10,3	52
53	TOTAL (lines 50 - 52)	1,968	$ 65,844		53

Facility Name & ID Number Taylorville Care Center, Inc. # 0028787 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rhonda Hancock	Administrator	0	$ 86,428
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,428

B. Administrative - Other

Description	Amount
Management Fee-King Management Company	$ 332,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 332,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting	$ 3,039
Mathis, Marifian & Richter, LTD	Legal/Collections	6,131
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 9,170

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,923
Unemployment Compensation Insurance	33,028
FICA Taxes	153,046
Employee Health Insurance	33,045
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	80
Employee Relations	1,836
Pension Expense-Employer Contributions	1,002
Employee Uniforms	2,384
Home Office Allocation	14,369
Employee Tuition Reimbursement	150
TOTAL (agree to Schedule V, line 22, col.8)	$ 288,863

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	6,320
Health Care Worker Background Check	1,250
(Indicate # of checks performed 125)	
Fingerprinting	1,075
Misc Dues & Licenses	1,133
IHCA Dues	4,187
Home Office Allocation	248
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,203

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,020
Home Office Allocation	345
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,365

* Attach copy of IMRF notifications

**See instructions.

TAYLORVILLE CARE CENTER, INC.
Legal Fees
ATTACHMENT TO SCHEDULE XIX-C
12/31/2018

Invoice Date	Law Firm Name	Allowable/Non-allowable	Amount	Description
8/31/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	120.00	Patient account collections
9/30/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	580.00	Patient account collections
10/31/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	1,661.02	Patient account collections
11/30/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	3,250.00	Patient account collections
12/31/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	520.00	Patient account collections
			6,131.02	all are non-allowable

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 $4,187**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **1,375** 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 fo
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 Departmen
during this cost report period. $ **198,795**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
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 othe
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) 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