

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0028787

Facility Name: Taylorville Care Center

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Amy Elik, Chief Financial Officer Telephone Number: (618) 327-3064 ext227
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 01/01/2016 to 12/31/2016 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) Denise King
(Title) President

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

0028787 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

N/A

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,815</u>	<u>1,815</u>	8
9	SNF/PED					9
10	ICF	<u>14,727</u>	<u>9,752</u>	<u>378</u>	<u>24,857</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,727</u>	<u>9,752</u>	<u>2,193</u>	<u>26,672</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.36%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☐

NO

☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started

08/01/1984

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date

08/01/1984

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

24

and days of care provided

1,667

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year:

12/31/2016

Fiscal Year:

12/31/2016

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2016 Ending: 12/31/2016
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	148,386	14,637	9,076	172,099		172,099		172,099			1
2	Food Purchase		144,752		144,752		144,752	(1,748)	143,004			2
3	Housekeeping	77,345	12,845		90,190		90,190	322	90,512			3
4	Laundry	68,191	9,650		77,841		77,841		77,841			4
5	Heat and Other Utilities			101,670	101,670		101,670	(6,647)	95,023			5
6	Maintenance	70,303	25,148	12,573	108,024		108,024	2,987	111,011			6
7	Other (specify):* Sanitation			5,294	5,294		5,294		5,294			7
8	TOTAL General Services	364,225	207,032	128,613	699,870		699,870	(5,086)	694,784			8
	B. Health Care and Programs											
9	Medical Director			10,400	10,400		10,400		10,400			9
10	Nursing and Medical Records	1,337,505	78,604	5,524	1,421,633		1,421,633	(770)	1,420,863			10
10a	Therapy											10a
11	Activities	42,627	4,873	2,284	49,784	500	50,284		50,284			11
12	Social Services	49,208	21	3,283	52,512	(500)	52,012		52,012			12
13	CNA Training											13
14	Program Transportation		6,859		6,859		6,859		6,859			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,429,340	90,357	21,491	1,541,188		1,541,188	(770)	1,540,418			16
	C. General Administration											
17	Administrative	85,672	6,395	210,000	302,067	(4,206)	297,861	(125,772)	172,089			17
18	Directors Fees											18
19	Professional Services			22,947	22,947	4,206	27,153	(7,687)	19,466			19
20	Dues, Fees, Subscriptions & Promotions			57,296	57,296		57,296	(44,801)	12,495			20
21	Clerical & General Office Expenses	34,665	11,767	52,601	99,033		99,033	73,853	172,886			21
22	Employee Benefits & Payroll Taxes			243,962	243,962		243,962	10,650	254,612			22
23	Inservice Training & Education			690	690		690		690			23
24	Travel and Seminar			762	762		762	115	877			24
25	Other Admin. Staff Transportation			75	75		75	349	424			25
26	Insurance-Prop.Liab.Malpractice			56,517	56,517		56,517	998	57,515			26
27	Other (specify):*											27
28	TOTAL General Administration	120,337	18,162	644,850	783,349		783,349	(92,295)	691,054			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,913,902	315,551	794,954	3,024,407		3,024,407	(98,151)	2,926,256			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			78,706	78,706		78,706	3,224	81,930			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			48,613	48,613		48,613		48,613			33
34	Rent-Facility & Grounds							4,673	4,673			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			127,319	127,319		127,319	7,897	135,216			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		60,225	200,470	260,695		260,695		260,695			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			207,975	207,975		207,975		207,975			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		60,225	408,445	468,670		468,670		468,670			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,913,902	375,776	1,330,718	3,620,396		3,620,396	(90,254)	3,530,142			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
12/31/2016

Activities	Line 11	500
Social Services	Line 12	(500)

Reclass cost of activities consultant to correct line

Administrative	Line 17	(4,206)
Professional Services	Line 19	4,206

Reclass accounting fees to correct line

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	(562)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,519)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,186)	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	(21,154)	20		18
19	Entertainment	(1,455)	17		19
20	Contributions	(585)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,720)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,969)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,645)	20		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,699)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (68,494)		\$	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)	(21,760)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (21,760)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (90,254)		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

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	To eliminate lobbying portion of IHCA dues	\$ (2,267)	20	1
2	Adjust depreciation for cost report purposes	(1,293)	30	2
3	Eliminate Chamber of Commerce Dues	(379)	20	3
4	Adjust for 2017 license fee paid in 2016	(1,990)	20	4
5	Offset reimbursement for printing copies	(770)	10	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,699)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center# 0028787

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,748)	0	0	0	0	0	0	0	0	0	0	(1,748)	2
3	Housekeeping	0	322	0	0	0	0	0	0	0	0	0	322	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(7,519)	872	0	0	0	0	0	0	0	0	0	(6,647)	5
6	Maintenance	0	2,987	0	0	0	0	0	0	0	0	0	2,987	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,267)	4,181	0	0	0	0	0	0	0	0	0	(5,086)	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	(770)	0	0	0	0	0	0	0	0	0	0	(770)	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	(770)	0	0	0	0	0	0	0	0	0	0	(770)	16
	C. General Administration													
17	Administrative	(1,455)	(124,317)	0	0	0	0	0	0	0	0	0	(125,772)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,720)	3,033	0	0	0	0	0	0	0	0	0	(7,687)	19
20	Fees, Subscriptions & Promotions	(44,989)	188	0	0	0	0	0	0	0	0	0	(44,801)	20
21	Clerical & General Office Expenses	0	73,853	0	0	0	0	0	0	0	0	0	73,853	21
22	Employee Benefits & Payroll Taxes	0	10,650	0	0	0	0	0	0	0	0	0	10,650	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	115	0	0	0	0	0	0	0	0	0	115	24
25	Other Admin. Staff Transportation	0	349	0	0	0	0	0	0	0	0	0	349	25
26	Insurance-Prop.Liab.Malpractice	0	998	0	0	0	0	0	0	0	0	0	998	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(57,164)	(35,131)	0	0	0	0	0	0	0	0	0	(92,295)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(67,201)	(30,950)	0	0	0	0	0	0	0	0	0	(98,151)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,293)	4,517	0	0	0	0	0	0	0	0	0	3,224	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	4,673	0	0	0	0	0	0	0	0	0	4,673	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	(1,293)	9,190	0	0	0	0	0	0	0	0	0	7,897	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(68,494)	(21,760)	0	0	0	0	0	0	0	0	0	(90,254)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Denise King 2011 Exempt Trust	20	Mt. Vernon Countryside Manor, Inc.	Mt. Vernon, IL	King Management Co.	O'Fallon, IL	Home Office
Leslie Pedtke 2011 Exempt Trust	20	Aviston Countryside Manor, Inc.	Aviston, IL	Residential Living Ctr	Mt. Vernon, IL	Assisted Living
Keith King 2011 Exempt Trust	20			Taylorville Estates	Taylorville, IL	Assisted Living
Elizabeth Todorov 2011 Exempt Trust	20			Trenton Village	Trenton, IL	Assrd Liv/Mem Care
Michelle Hirschfield 2011 Exempt Trust	20					

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	See Schedule VIII	\$	King Management Company	0.00%	\$ 322	\$ 322	1
2	V	5	See Schedule VIII		King Management Company	0.00%	872	872	2
3	V	6	See Schedule VIII		King Management Company	0.00%	2,987	2,987	3
4	V	17	See Schedule VIII	210,000	King Management Company	0.00%	85,683	(124,317)	4
5	V	19	See Schedule VIII		King Management Company	0.00%	3,033	3,033	5
6	V	20	See Schedule VIII		King Management Company	0.00%	188	188	6
7	V	21	See Schedule VIII		King Management Company	0.00%	73,853	73,853	7
8	V	22	See Schedule VIII		King Management Company	0.00%	10,650	10,650	8
9	V	24	See Schedule VIII		King Management Company	0.00%	115	115	9
10	V	25	See Schedule VIII		King Management Company	0.00%	349	349	10
11	V	26	See Schedule VIII		King Management Company	0.00%	998	998	11
12	V	30	See Schedule VIII		King Management Company	0.00%	4,517	4,517	12
13	V	34	See Schedule VIII		King Management Company	0.00%	4,673	4,673	13
14	Total			\$ 210,000			\$ 188,240	\$ * (21,760)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Denise King	President	Administrative	20.00	214,156	10	25.00	Salary	\$ 85,607	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 85,607		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 # 0028787 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	3	Housekeeping	Accumulated Costs	13,397,043	6	\$ 1,264	\$	3,410,396	\$ 322	1
2	5	Utilities	Accumulated Costs	13,397,043	6	3,425		3,410,396	872	2
3	6	Maintenance	Accumulated Costs	13,397,043	6	11,735		3,410,396	2,987	3
4	17	Administrative	Accumulated Costs	13,397,043	6	336,590	339,291	3,410,396	85,683	4
5	19	Professional Fees	Accumulated Costs	13,397,043	6	11,916		3,410,396	3,033	5
6	20	Dues, Fee, & Subscriptions	Accumulated Costs	13,397,043	6	739		3,410,396	188	6
7	21	Clerical & Office Expense	Accumulated Costs	13,397,043	6	290,118	237,401	3,410,396	73,853	7
8	22	Emp Benefits & Payroll Taxes	Accumulated Costs	13,397,043	6	41,836		3,410,396	10,650	8
9	24	Travel & Seminar	Accumulated Costs	13,397,043	6	450		3,410,396	115	9
10	25	Other Administrative Transp.	Accumulated Costs	13,397,043	6	1,371		3,410,396	349	10
11	26	Insurance	Accumulated Costs	13,397,043	6	3,922		3,410,396	998	11
12	30	Depreciation	Accumulated Costs	13,397,043	6	17,743		3,410,396	4,517	12
13	34	Rent-Facility & Grounds	Accumulated Costs	13,397,043	6	18,355		3,410,396	4,673	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					\$ 739,464	\$ 576,692		\$ 188,240	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Schedule Not Applicable						\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

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

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

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

B. Real Estate Taxes

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Taylorville Care Center 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 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 17-13-28-401-005-00	Cheneys Add Lts 1 Thru 6 Blk 3	\$ 48,612.64	\$ 48,612.64
2.	& Lts 1 Thru 6 Blk 4 & OL 1 &	\$	\$
3.	Vac Austin St. & Alley	\$	\$
4.	282X652 13-28-G	\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 48,612.64	\$ 48,612.64

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

A. Square Feet: 26,610

B. General Construction Type: Exterior Brick Frame Non-Comb Sprinkle Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
Taylorville Estates is a 49 Unit (27, 945 square foot) retirement center which is located on the property adjacent to Taylorville Care Center.

E. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	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

0028787

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	Water Heater-disposed in 2016		1993				15				18
19	Air Conditioner		1993		2,800		10			2,800	19
20	New Office		1993		1,500	37	40	37		863	20
21	4 Inch Backflow Preventer		1994		3,966	159	25	159		3,649	21
22	Carpeting		1994		2,471		10			2,471	22
23	Circulating Pump on Water Heater-disposed in 2016		1994				14				23
24	Fence		1995		3,590		15			3,590	24
25	Water Heater-disposed in 2016		1995				15				25
26	Sprinkler Heads		1995		1,600		15			1,600	26
27	New Roof		1996		25,000		10			25,000	27
28	Water Softener-disposed in 2016		1996				12				28
29	Ceramic Tile		1997		5,167		10			5,167	29
30	Garage		1997		7,841		10			7,841	30
31	Rooftop A/C, Ducts and Gas Lines		1997		10,940		10			10,940	31
32	Beauty Shop Addition		1997		6,823		15			6,823	32
33	Carpeting		1998		4,154		10			4,154	33
34	Windows-disposed in 2016		1998				10				34
35	Heating and A/C Units		1998		4,128		5			4,128	35
36	Air Conditioner Units		1999		25,051		10			25,051	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Rear Parking Lot/Driveway	1999	\$ 2,996	\$	10	\$	\$	\$ 2,996	37
38 Air Conditioner Units	2000	4,834		10			4,834	38
39 Landscaping	2001	2,300		10			2,300	39
40 Electrical	2001	6,725		10			6,725	40
41 Cabinets	2001	27,444	1,372	20	1,372		21,613	41
42 Water Heater-disposed in 2016	2001		193	15	193			42
43 Wallpaper & Installation	2002	9,016		5			9,016	43
44 Wallguards	2002	5,729	382	15	382		5,634	44
45 Water Heater	2002	6,759	451	15	451		6,421	45
46 Carpet/Baseboard Remodel	2002	16,561		10			16,561	46
47 Landscaping	2004	5,106		10			5,106	47
48 20' Gazebo	2004	24,761	1,651	15	1,651		20,221	48
49 Parking Lot	2004	27,200		8			27,200	49
50 Lawn Sprinkler System	2004	3,850	257	15	257		3,166	50
51 Landscaping	2004	8,977		10			8,977	51
52 Vinyl Fence	2004	5,219		10			5,219	52
53 Facility Sign	2004	2,632		10			2,632	53
54 100 Gallon Water Heater	2004	2,390		10			2,390	54
55 Sidewalk	2004	1,920	128	15	128		1,579	55
56 Telephone System	2004	4,337		10			4,337	56
57 Concrete Sidewalk	2005	3,100	207	15	207		2,325	57
58 Storage Building	2006	4,030	202	20	202		2,032	58
59 Fire System Upgrade	2007	5,577	558	7		(558)	5,577	59
60 Carpet	2007	31,573		5			31,573	60
61 Wallpaper	2007	43,285		5			43,285	61
62 Wallpaper	2007	17,086		5			17,086	62
63 Rooftop Vents	2007	2,309	231	10	231		2,309	63
64 Sidewalk	2007	6,785	339	15	452	113	4,071	64
65 Water Softener System	2010	4,700	470	10	470		2,937	65
66 Tile Flooring	2010	2,244	224	10	224		1,421	66
67 Plumbing Upgrades	2010	21,525	1,076	20	1,076		7,354	67
68 Ceramic Tile	2010	15,575	779	20	779		4,737	68
69 Vinyl Tile	2010	1,320	132	10	132		792	69
70 TOTAL (lines 4 thru 69)		\$ 2,083,357	\$ 8,848		\$ 8,403	\$ (445)	\$ 2,036,964	70

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

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,083,357	\$ 8,848		\$ 8,403	\$ (445)	\$ 2,036,964	1
2	Ceramic Tile	2010	32,565	1,628	20	1,628		10,041	2
3	Light Fixtures	2011	2,423	242	10	242		1,332	3
4	Cabinetry & Built-In Desk for Therapy	2011	5,898	393	15	393		2,195	4
5	Roof	2011	50,303	3,354	15	3,354		18,165	5
6	Cherry Flooring	2011	14,258	1,426	10	1,426		7,486	6
7	Shower Room Tile	2011	3,477	232	15	232		1,256	7
8	Flat Roof	2011	11,269	1,127	10	1,127		6,010	8
9	Roof & Parapet Wall	2011	51,757	3,450	15	3,450		17,252	9
10	Wallpaper & Border	2011	8,393	1,539	5	1,539		8,393	10
11	Tile Flooring Installation	2011	10,000	1,000	10	1,000		5,083	11
12	Custom Nurses' Station	2011	27,690	1,846	15	1,846		9,384	12
13	Hand Rail & Crash Rail	2011	8,946	596	15	596		3,032	13
14	Water Heater	2012	4,114	411	10	411		2,023	14
15	Walk-In Cooler Condensing Unit	2012	2,774	185	15	185		817	15
16	Building Generator	2013	51,847	2,592	20	2,592		8,209	16
17	Gazebo	2013	1,257	84	15	84		279	17
18	Concrete Drive	2013	12,954	864	15	864		3,095	18
19	Concrete Dumpster Pad & Walk	2013	3,700	247	15	247		822	19
20	Cabinets & Countertop	2013	3,010	201	15	201		602	20
21	Rooftop A/C System - 5-ton	2013	5,288	529	10	529		1,586	21
22	Paint Ceilings in A & C	2014	11,643	2,329	5	2,329		6,792	22
23	Paint Ceilings in Main Hallway	2014	2,800	560	5	560		1,587	23
24	Paint Ceilings in 15 Rooms	2014	9,000	1,800	5	1,800		4,350	24
25	Hallway Lighting	2014	2,080	208	10	208		572	25
26	Fitness Room Lighting	2014	2,430	243	10	243		648	26
27	5-ton Roof-Top HVAC	2014	5,352	357	15	357		743	27
28	Cable Wiring A Hall	2014	2,600	144	18	144		349	28
29	100 Gal Water Heater	2015	5,157	516	10	516		730	29
30	New Steel Service Door & Frame	2015	8,268	413	20	413		448	30
31	Concrete Work	2015	3,650	243	15	243		304	31
32	Additional 2011 Assets			616			(616)		32
33	Drywall & Painting	2016	11,740	783	15	783		783	33
34	TOTAL (lines 1 thru 33)		\$ 2,460,000	\$ 39,006		\$ 37,945	\$ (1,061)	\$ 2,161,332	34

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

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 2,460,000	\$ 39,006		\$ 37,945	\$ (1,061)	\$ 2,161,332	1
2 Water Heater	2016	5,897	344	10	344		344	2
3 5 Ton Gas/Electric Rooftop HVAC	2016	5,582	46	10	46		46	3
4 New Windows Entire Facility	2016	93,937	391	20	391		391	4
5								5
6 Home Office Additions:								6
7 Front Door-disposed in 2016	2002			10				7
8 Wallpaper-disposed in 2016	2007			10	10	10		8
9 Wallpaper-disposed in 2016	2008			5				9
10 Carpet-disposed in 2016	2008			5				10
11 Tile Flooring-disposed in 2016	2009			10	7	7		11
12 Wallpaper-disposed in 2016	2009			5				12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,565,416	\$ 39,787		\$ 38,743	\$ (1,044)	\$ 2,162,113	34

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

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,565,416	\$ 39,787		\$ 38,743	\$ (1,044)	\$ 2,162,113	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,565,416	\$ 39,787		\$ 38,743	\$ (1,044)	\$ 2,162,113	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$283,434	\$33,228	\$34,361	\$1,133	3-20 Yrs	\$156,912	71
72	Current Year Purchases	20,702	689	1,797	1,108	3-20 Yrs	1,797	72
73	Fully Depreciated Assets	219,291					219,291	73
74								74
75	TOTALS	\$523,427	\$33,917	\$36,158	\$2,241		\$378,000	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-disposed in 2016	Chevrolet Bus	2007	\$	\$	\$	\$	4	\$	76
77	Facility	2013 Ford E450 Bus	2016	40,015	5,002	5,002		4	5,002	77
78										78
79	Home Office Vehicle	2012 Acura	2012	8,109		2,027	2,027	4	8,109	79
80	TOTALS			\$48,124	\$5,002	\$7,029	\$2,027		\$13,111	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)	\$3,176,967	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$78,706	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$81,930	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$3,224	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,553,224	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: [Section Not Applicable](#)

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

If NO, see instructions.

☐ YES ☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ N/A NO Terms: *

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 Not Applicable		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending Annual Rent

12. /2017 \$

13. /2018 \$

14. /2019 \$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

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.)										
		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				59,831		59,831	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): Therapy	39,3				187,186			187,186	12
13	Other (specify): Lab,X-Ray,Ambul,Sup	39,3 & 39,2				13,284	394		13,678	13
14	TOTAL			\$		\$ 200,470	\$ 60,225		\$ 260,695	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.

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	\$ 884,409	\$	1
2	Cash-Patient Deposits	10,073		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,000)	1,424,208		3
4	Supply Inventory (priced at Cost)	6,072		4
5	Short-Term Investments			5
6	Prepaid Insurance	4,350		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,329,112	\$	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	2,540,245		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	540,867		16
17	Accumulated Depreciation (book methods)	(2,510,754)		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)	\$ 610,358	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,939,470	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 19,113	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,073		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,708		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,637		31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to related parties</u>	4,018		36
37	<u>Accrued Provider Taxes</u>	26,344		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 270,893	\$	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)	\$ 270,893	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,668,577	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,939,470	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,736,615	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,736,615	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	554,287	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	(622,325)	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)	\$ (68,038)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,668,577	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Taylorville Care Center

0028787

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,711,448	1
2	Discounts and Allowances for all Levels	(1,137,057)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,574,391	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	587,210	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 587,210	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	562	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	6,972	19
20	Radiology and X-Ray	4,870	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,404	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	670	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 670	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,174,683	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	699,870	31
32	Health Care	1,541,188	32
33	General Administration	783,349	33
	B. Capital Expense		
34	Ownership	127,319	34
	C. Ancillary Expense		
35	Special Cost Centers	260,695	35
36	Provider Participation Fee	207,975	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,620,396	40
41	Income before Income Taxes (line 30 minus line 40)**	554,287	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 554,287	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,825,859	44
45	Private Pay - Net Inpatient Revenue	1,475,666	45
46	Medicare - Net Inpatient Revenue	272,866	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,574,391	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
12/31/2016

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 554,287
DEPRECIATION ADJUSTMENT	11,816
CONVERSION TO CASH BASIS ADJUSTMENTS	123,385
OTHER MISC BOOK TO TAX ADJUSTMENTS	23,734
TAX NET INCOME	<u>\$ 713,222</u>

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,936	2,230	\$ 71,314	\$ 31.98	1
2	Assistant Director of Nursing	2,027	2,195	50,018	22.79	2
3	Registered Nurses	4,626	4,754	111,604	23.48	3
4	Licensed Practical Nurses	21,412	22,042	396,757	18.00	4
5	CNAs & Orderlies	52,011	52,415	567,319	10.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,185	2,524	35,287	13.98	8
9	Activity Director	1,425	1,390	15,616	11.23	9
10	Activity Assistants	2,764	2,868	27,011	9.42	10
11	Social Service Workers	4,097	4,493	49,208	10.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,858	15,541	148,386	9.55	15
16	Dishwashers					16
17	Maintenance Workers	4,700	4,909	70,303	14.32	17
18	Housekeepers	8,190	8,607	77,345	8.99	18
19	Laundry	6,401	6,916	68,191	9.86	19
20	Administrator	1,881	2,127	85,672	40.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,299	2,505	34,665	13.84	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	1,752	1,889	20,032	10.60	31
32	Other Health Care MDS/Care Plans	3,747	4,141	85,174	20.57	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,311	141,546	\$ 1,913,902 *	\$ 13.52	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	142	\$ 8,316	1,3	35
36	Medical Director	Contract	10,400	9,3	36
37	Medical Records Consultant	34	2,518	10,3	37
38	Nurse Consultant	3	375	10,3	38
39	Pharmacist Consultant	Contract	2,631	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	38	2,784	11,3	44
45	Social Service Consultant	38	2,783	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	255	\$ 29,807		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Rhonda Hancock	Administrator	0	\$ 85,672	Workers' Compensation Insurance	\$	47,045	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		30,106	Advertising: Employee Recruitment	3,295	
				FICA Taxes		139,800	Health Care Worker Background Check		
				Employee Health Insurance		24,127	(Indicate # of checks performed 70)	700	
				Employee Meals			Fingerprinting	955	
				Illinois Municipal Retirement Fund (IMRF)*			IHCA Dues	3,613	
				Employee Physicals		145	Mincellaneous Dues & Licenses	1,754	
				Employee Relations		1,882			
				Pension Expense-Employer Contribution		857	Home Office Allocation	188	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)									
				Home Office Allocation		10,650	Less: Public Relations Expense	()	
							Non-allowable advertising	()	
							Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$	254,612	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,495	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description				Description			Description		
Amount				Line #			Amount		
Management Fee - King Management Company				Section N/A			Out-of-State Travel		
							In-State Travel		
							Seminar Expense		
							Home Office Allocation		
							Entertainment Expense		
							()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)		
</									

*** Attach copy of IMRF notifications**

****See instructions.**

TAYLORVILLE CARE CENTER, INC.
Legal Fees
ATTACHMENT TO SCHEDULE XIX-C
12/31/2016

<u>Invoice Date</u>	<u>Law Firm Name</u>	<u>Allowable/No n-allowable</u>	<u>Amount</u>	<u>Description</u>
1/28/2016	Greensfelder, Hemker & Gale	Allowable	181.25	Employee handbook revisions
1/31/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	1,024.00	Patient account collections
2/29/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	2,000.00	Patient account collections
3/31/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	828.00	Patient account collections
4/30/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	1,500.00	Patient account collections
5/31/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	240.00	Patient account collections
6/30/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	60.00	Patient account collections
8/31/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	800.00	Patient account collections
9/30/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	1,485.67	Patient account collections
10/31/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	891.00	Patient account collections
11/30/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	880.00	Patient account collections
12/31/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	1,011.00	Patient account collections
			<u>10,900.92</u>	

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>No</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>IHCA Dues \$3,613</u>
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?	<u>Yes</u> <u>Yes</u>
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>5-10 Yrs</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>30</u> Line <u>10</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> 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. This amount is to be recorded on line 42 of Schedule V.	\$ <u>207,975</u>
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	<u>No</u>
(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?	<u>None</u>
(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? (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.	<u>No</u>
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. Has any meal income been offset against related costs?	\$ <u>None</u> <u>Yes</u> Indicate the amount. \$ <u>562</u>
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.	<u>No</u> <u>No</u> \$ <u>N/A</u> <u>N/a</u> <u>Yes</u> <u>N/A</u> <u>No</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>No</u> <u>N/A</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?	<u>Yes</u>
(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. Attach invoices and a summary of services for all architect and appraisal fees	<u>Yes</u>