

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0056333

Facility Name: Aviston Countryside Manor

Address: 450 West 1st Street Aviston 62216

County: Clinton

Telephone Number: 618-228-7615 Fax # 618-228-7632

HFS ID Number:

Date of Initial License for Current Owners: 03/01/2020

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: Cindy A. Tefteller Telephone Number: (618) 465-7717

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 03/01/2020 to 12/31/2020 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)

(Type or Print Name) Jason Mills

(Title) Chief Financial Officer

Paid Preparer

(Signed) See Accountant's Preparation Report

(Print Name and Title) Cindy A. Tefteller Partner

(Firm Name & Address) C.J. Schlosser & Company, L.L.C 233 E. Center Drive, Alton, IL

(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE

ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES

201 S. Grand Avenue East

Springfield, IL 62763-0001

Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Aviston Countryside Manor

0056333 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>34</u>	Skilled (SNF)	<u>34</u>	<u>10,404</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>63</u>	Intermediate (ICF)	<u>63</u>	<u>19,278</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>29,682</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>3,323</u>	<u>3,323</u>	8
9	SNF/PED					9
10	ICF	<u>8,207</u>	<u>6,719</u>		<u>14,926</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,207</u>	<u>6,719</u>	<u>3,323</u>	<u>18,249</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.48%

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 ☒

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 2/23/1988

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 03/01/2020 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 32 and days of care provided 2,957

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Countryside Manor # 0056333 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

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	164,796	8,440	5,036	178,272		178,272		178,272			1
2	Food Purchase		125,347		125,347		125,347		125,347			2
3	Housekeeping	85,553	9,002		94,555		94,555		94,555			3
4	Laundry	42,015	8,594		50,609		50,609		50,609			4
5	Heat and Other Utilities			88,466	88,466		88,466	(3,450)	85,016			5
6	Maintenance	52,465	22,357	22,370	97,192		97,192	1,718	98,910			6
7	Other (specify):* Waste Removal			17,474	17,474		17,474		17,474			7
8	TOTAL General Services	344,829	173,740	133,346	651,915		651,915	(1,732)	650,183			8
	B. Health Care and Programs											
9	Medical Director			2,000	2,000		2,000		2,000			9
10	Nursing and Medical Records	1,362,897	98,555	35,014	1,496,466		1,496,466	34,652	1,531,118			10
10a	Therapy		156		156		156		156			10a
11	Activities	34,921	2,552	332	37,805		37,805		37,805			11
12	Social Services	25,415		2,015	27,430		27,430		27,430			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,423,233	101,263	39,361	1,563,857		1,563,857	34,652	1,598,509			16
	C. General Administration											
17	Administrative	60,956		230,600	291,556		291,556	(215,877)	75,679			17
18	Directors Fees											18
19	Professional Services			30,473	30,473		30,473	13,904	44,377			19
20	Dues, Fees, Subscriptions & Promotions			19,477	19,477		19,477	8,029	27,506			20
21	Clerical & General Office Expenses	30,726	5,351	57,398	93,475		93,475	127,383	220,858			21
22	Employee Benefits & Payroll Taxes			247,171	247,171		247,171	14,460	261,631			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,416	4,416		4,416	4,268	8,684			24
25	Other Admin. Staff Transportation			2,656	2,656		2,656	1,840	4,496			25
26	Insurance-Prop.Liab.Malpractice			71,224	71,224		71,224	13,252	84,476			26
27	Other (specify):*											27
28	TOTAL General Administration	91,682	5,351	663,415	760,448		760,448	(32,741)	727,707			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,859,744	280,354	836,122	2,976,220		2,976,220	179	2,976,399			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			1,563	1,563		1,563	3,318	4,881			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							3,867	3,867			32
33	Real Estate Taxes			30,996	30,996		30,996	23	31,019			33
34	Rent-Facility & Grounds			378,537	378,537		378,537	8,611	387,148			34
35	Rent-Equipment & Vehicles			780	780		780	575	1,355			35
36	Other (specify):*											36
37	TOTAL Ownership			411,876	411,876		411,876	16,394	428,270			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,462	364,865	467,327		467,327		467,327			39
40	Barber and Beauty Shops			65	65		65		65			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			143,489	143,489		143,489		143,489			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		102,462	508,419	610,881		610,881		610,881			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,859,744	382,816	1,756,417	3,998,977		3,998,977	16,573	4,015,550			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

	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	(4,630)	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				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,869)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,327)	20		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,826)		\$	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)	25,399	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 25,399		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 16,573		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lobbying/PAC Dues	\$ (2,327)	20	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,327)		49

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
Stephen Miller	100	Palladian Mt. Vernon SNF, LLC	Mt. Vernon	Palladian Management	O'Fallon, IL	Home Office
		Palladian Taylorville SNF, LLC	Taylorville	Palladian Mt. Vernon	Mt. Vernon, IL	Asstd Liv/MemCare
		Helia Healthcare of Belleville	Belleville	Palladian Taylorville A	Taylorville, IL	Asstd Living
		Helia Healthcare of Benton	Benton	Bridgemark Healthcar	St. Louis	Home Office
		Helia Healthcare of Effingham	Effingham			
		Helia Healthcare of Energy	Energy			
		Frankfort Healthcare & Rehab Center	West Frankfort			

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	5	See Schedule VIII	\$	Palladian Management	0.00%	\$ 1,180	\$ 1,180	1
2	V	6	See Schedule VIII		Palladian Management	0.00%	1,718	1,718	2
3	V	10	See Schedule VIII		Palladian Management	0.00%	34,652	34,652	3
4	V	17	See Schedule VIII	230,600	Palladian Management	0.00%	14,723	(215,877)	4
5	V	19	See Schedule VIII		Palladian Management	0.00%	13,904	13,904	5
6	V	20	See Schedule VIII		Palladian Management	0.00%	12,225	12,225	6
7	V	21	See Schedule VIII		Palladian Management	0.00%	127,383	127,383	7
8	V	22	See Schedule VIII		Palladian Management	0.00%	14,460	14,460	8
9	V	24	See Schedule VIII		Palladian Management	0.00%	4,268	4,268	9
10	V	25	See Schedule VIII		Palladian Management	0.00%	1,840	1,840	10
11	V	26	See Schedule VIII		Palladian Management	0.00%	13,252	13,252	11
12	V	30	See Schedule VIII		Palladian Management	0.00%	3,318	3,318	12
13	V	32	See Schedule VIII		Palladian Management	0.00%	3,867	3,867	13
14	Total			\$ 230,600			\$ 246,790	\$ * 16,190	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	33	See schedule VIII	\$	Palladian Management	0.00%	\$ 23	\$ 23	15
16	V	34	See schedule VIII		Palladian Management	0.00%	8,611	8,611	16
17	V	35	See schedule VIII		Palladian Management	0.00%	575	575	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			\$			\$ 9,209	\$ * 9,209	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Aviston Countryside Manor

0056333

Report Period Beginning:

03/01/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Helia Healthcare of Florissant	Florissant				1
2			Helia Healthcare of Hillsboro	Hillsboro				2
3			Hillside Rehab & Care Center	Yorkville				3
4			Helia Healthcare of Jerseyville	Jerseyville				4
5			Helia Healthcare of Olney	Olney				5
6			Helia Healthcare of Poplar Bluff	Poplar Bluff				6
7			Helia Healthcare of Salem	Salem				7
8			Helia Southbelt Healthcare	Belleville				8
9			Palladian Senior Care of Poplar Bluff	Poplar Bluff				9
10			Helia Healthcare of Richland	Olney				10
11			Helia Healthcare of Newton	Newton				11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Countryside Manor # 0056333 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

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	Stephen Miller	Owner	Administrative	100.00	391,705	1.81	3.62	Salary	\$ 14,723	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	\$ 14,723		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Countryside Manor# 0056333

Report Period Beginning:

03/01/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Palladian Management - King

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Heat & Other Utilities	Accumulated Costs	5	\$ 4,744	\$	3,765,369	\$ 1,180	1
2	6	Maintenance	Accumulated Costs	5	6,910		3,765,369	1,718	2
3	10	Nursing & Med Rec - Salaries	Accumulated Costs	5	136,053	13,053	3,765,369	33,828	3
4	10	Nursing & Med Rec - Supplies	Accumulated Costs	5	3,313		3,765,369	824	4
5	17	Owners Compensation	Accumulated Costs	5	59,215		3,765,369	14,723	5
6	19	Professional Services	Accumulated Costs	5	55,919		3,765,369	13,904	6
7	20	Dues & Subscriptions	Accumulated Costs	5	49,166		3,765,369	12,225	7
8	21	Other - Salaries	Accumulated Costs	5	392,257	392,257	3,765,369	97,531	8
9	21	Clerical & Office Supplies	Accumulated Costs	5	120,060		3,765,369	29,852	9
10	22	Employee Benefits	Accumulated Costs	5	58,155		3,765,369	14,460	10
11	24	Travel & Seminar	Accumulated Costs	5	17,167		3,765,369	4,268	11
12	25	Other Admin Transportation	Accumulated Costs	5	7,401		3,765,369	1,840	12
13	26	Insurance	Accumulated Costs	5	53,298		3,765,369	13,252	13
14	30	Depreciation	Accumulated Costs	5	13,344		3,765,369	3,318	14
15	32	Interest	Accumulated Costs	5	15,552		3,765,369	3,867	15
16	33	Real Estate Taxes	Accumulated Costs	5	92		3,765,369	23	16
17	34	Building Rent	Accumulated Costs	5	33,298		3,765,369	8,279	17
18	34	Rental - Storage Unit	Accumulated Costs	5	1,335		3,765,369	332	18
19	35	Equipment Rental	Accumulated Costs	5	2,313		3,765,369	575	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,029,592	\$ 405,310		\$ 255,999	25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Palladian Management Allocation			Working Capital								3,867	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 3,867	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$ 3,867	15

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

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

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

FACILITY NAME Aviston Countryside Manor COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0056333

CONTACT PERSON REGARDING THIS REPORT Jason Mills

TELEPHONE 314-317-2003 FAX #: 314-754-9176

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

28,618

B. General Construction Type:

Exterior Brick

Frame

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).

N/A

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	New Office Build Out - Home Office			2011	4,920		20	261	261	2,463
10	Conference Room Chair Rail & Paint - Home Office			2012	56		20			56
11	AC Unit in Server Room - Home Office			2018	382		20	19	19	48
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

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Countryside Manor

0056333

Report Period Beginning:

03/01/2020 Ending: 12/31/2020

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			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,358	\$		\$ 280	\$ 280	\$ 2,567	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 5,773	\$	\$ 1,571	\$ 1,571		\$ 3,267	71
72	Current Year Purchases	19,438	1,563	3,030	1,467		3,030	72
73	Fully Depreciated Assets	1,740					1,740	73
74								74
75	TOTALS	\$ 26,951	\$ 1,563	\$ 4,601	\$ 3,038		\$ 8,037	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	None			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 32,309	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,563	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 4,881	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,318	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,604	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	None	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: J-Dek Holdings
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:	1988	97	03/01/2020	\$ 378,537	15		3
4	Additions							4
5								5
6								6
7	TOTAL		97		\$ 378,537			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 .

0

0
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 780 Description: copier lease
(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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

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.

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				102,462		102,462	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab, X-Ray, Therapies</u>					364,865			364,865	12
13	Other (specify): <u> </u>									

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 544,681	\$	1
2	Cash-Patient Deposits	2,418		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 47,000)	498,388		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,406		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,046,893	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	8,038		16
17	Accumulated Depreciation (book methods)	(1,563)		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): Deposits	214,766		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 221,241	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,268,134	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 95,094	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,816		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,419		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	21,794		36
37	Deferred Revenue - CARES Funds	232,217		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 415,340	\$	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	Related Parties	379,787		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 379,787	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 795,127	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 473,007	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,268,134	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	473,007	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	()	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)	\$ 473,007	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)	\$ 473,007	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Countryside Manor

0056333

Report Period Beginning: 03/01/2020

Ending: 12/31/2020

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	\$ 4,900,264	1
2	Discounts and Allowances for all Levels	(583,608)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,316,656	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	155,032	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 155,032	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		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	296	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 296	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,471,984	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	651,915	31
32	Health Care	1,563,857	32
33	General Administration	760,448	33
	B. Capital Expense		
34	Ownership	411,876	34
	C. Ancillary Expense		
35	Special Cost Centers	467,392	35
36	Provider Participation Fee	143,489	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,998,977	40
41	Income before Income Taxes (line 30 minus line 40)**	473,007	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 473,007	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,143,283	44
45	Private Pay - Net Inpatient Revenue	1,409,957	45
46	Medicare - Net Inpatient Revenue	1,556,778	46
47	Other-(specify) <u>Managed Care</u>	206,638	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,316,656	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,601	1,749	\$ 58,615	\$ 33.51	1
2	Assistant Director of Nursing	1,576	1,629	47,213	28.98	2
3	Registered Nurses	8,917	9,289	253,170	27.25	3
4	Licensed Practical Nurses	12,785	13,495	331,246	24.55	4
5	CNAs & Orderlies	44,933	46,509	649,868	13.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,409	2,591	34,921	13.48	10
11	Social Service Workers	1,587	1,673	25,415	15.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,507	13,093	164,796	12.59	15
16	Dishwashers					16
17	Maintenance Workers	1,777	1,937	52,465	27.09	17
18	Housekeepers	7,259	7,572	85,553	11.30	18
19	Laundry	3,081	3,290	42,015	12.77	19
20	Administrator	1,388	1,513	60,956	40.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,758	1,834	30,726	16.75	23
24	Clerical					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	1,619	1,661	22,785	13.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	103,197	107,835	\$ 1,859,744 *	\$ 17.25	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		\$ 5,036	1, 3	35
36	Medical Director		2,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,779	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		135	11, 3	44
45	Social Service Consultant		2,015	11,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 10,965		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides		32,651	10, 3	52
53	TOTAL (lines 50 - 52)		\$ 32,651		53

SEE ACCOUNTANTS' PREPARATION REPORT

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	
Tara Hamilton	Administrator	0	\$ 51,437	Workers' Compensation Insurance	\$	29,284	IDPH License Fee	\$ 1,990	
Monica Vasquez	Administrator	0	9,519	Unemployment Compensation Insurance		40,070	Advertising: Employee Recruitment	222	
				FICA Taxes		136,637	Health Care Worker Background Check		
				Employee Health Insurance		37,389	(Indicate # of checks performed _____)	1,915	
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Public Relations	1,869	
				Retirement Plan		2,215	IHCA Dues	4,924	
				Employee Relations		1,576	Subscriptions	2,142	
				Related Party Allocation		14,460	Misc Licenses & Fees	4,088	
							Related Party Allocation	12,225	
							Less: Public Relations Expense	(1,869)	
							Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)							TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)			\$ 60,956			\$ 261,631	\$ 27,506		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Palladian Management			\$ 230,600	Section N/A		\$	Out-of-State Travel	\$	
							In-State Travel	168	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 230,600				Related Party allocation	4,268	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
Paycom Payroll	Payroll Services		\$ 20,673						
Old Second National Bank	Legal Fees		9,800						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 30,473				TOTAL		

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

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?
If YES, give association name and amount.

Yes
IHCA - \$4,924
- (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?

Yes
Yes
- (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?

No
N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
3
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$0Line10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A
- (9) Are you presently operating under a sublease agreement?

YESXNO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YESNO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X
- (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.

\$143,489
- (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.

No
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
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.

No
- (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?

\$None
NoneIndicate the amount. \$0
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

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.

No
N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

N/A

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

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

No
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.
Attach invoices and a summary of services for all architect and appraisal fees.

Yes

SEE ACCOUNTANTS' PREPARATION REPORT