

		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.

<p>I. IDPH License ID Number: <u>0056333</u></p> <p>Facility Name: <u>Aviston Countryside Manor</u></p> <p>Address: <u>450 West 1st Street</u> <u>Aviston</u> <u>62216</u> <small>Number City Zip Code</small></p> <p>County: <u>Clinton</u></p> <p>Telephone Number: <u>618-228-7615</u> Fax # <u>618-228-7632</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>03/01/2020</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>03/01/2020</u> to <u>12/31/2020</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>Jason Mills</u> (Title) <u>Chief Financial Officer</u> </td> </tr> <tr> <td style="width:20%; vertical-align: top;"> Paid Preparer </td> <td> (Signed) <u>See Accountant's Preparation Report</u> (Print Name and Title) <u>Cindy A. Tefteller Partner</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C 233 E. Center Drive, Alton, IL</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u> </td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Jason Mills</u> (Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) <u>See Accountant's Preparation Report</u> (Print Name and Title) <u>Cindy A. Tefteller Partner</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C 233 E. Center Drive, Alton, IL</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' PREPARATION REPORT

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	34	Skilled (SNF)	34	10,404	1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	19,278	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	29,682	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,323	3,323	8
9	SNF/PED					9
10	ICF	8,207	6,719		14,926	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,207	6,719	3,323	18,249	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

ACCRUAL 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.

Facility Name & ID Number

Aviston Countryside Manor

#0056333

Report Period Beginning:

03/01/2020

Ending:

12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
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
45	GRAND TOTAL COST (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

Facility Name & ID Number Aviston Countryside Manor

0056333

Report Period Beginning:

03/01/2020

Ending:

12/31/2020

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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

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	2	
		Amount	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
	(sum of SUBTOTALS			
37	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	2	3	4
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' PREPARATION REPORT

Aviston Countryside Manor

ID# 0056333

Report Period Beginning: 03/01/2020

Ending: 12/31/2020

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
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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25				25
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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	(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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
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.

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	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:

03/01/2020

Ending: 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

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

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

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	15,143,754	5	\$ 4,744	\$ 3,765,369	\$ 1,180	1
2	6	Maintenance	Accumulated Costs	15,143,754	5	6,910	3,765,369	1,718	2
3	10	Nursing & Med Rec - Salaries	Accumulated Costs	15,143,754	5	136,053	13,053	3,765,369	33,828
4	10	Nursing & Med Rec - Supplies	Accumulated Costs	15,143,754	5	3,313	3,765,369	824	4
5	17	Owners Compensation	Accumulated Costs	15,143,754	5	59,215	3,765,369	14,723	5
6	19	Professional Services	Accumulated Costs	15,143,754	5	55,919	3,765,369	13,904	6
7	20	Dues & Subscriptions	Accumulated Costs	15,143,754	5	49,166	3,765,369	12,225	7
8	21	Other - Salaries	Accumulated Costs	15,143,754	5	392,257	392,257	3,765,369	97,531
9	21	Clerical & Office Supplies	Accumulated Costs	15,143,754	5	120,060	3,765,369	29,852	9
10	22	Employee Benefits	Accumulated Costs	15,143,754	5	58,155	3,765,369	14,460	10
11	24	Travel & Seminar	Accumulated Costs	15,143,754	5	17,167	3,765,369	4,268	11
12	25	Other Admin Transportation	Accumulated Costs	15,143,754	5	7,401	3,765,369	1,840	12
13	26	Insurance	Accumulated Costs	15,143,754	5	53,298	3,765,369	13,252	13
14	30	Depreciation	Accumulated Costs	15,143,754	5	13,344	3,765,369	3,318	14
15	32	Interest	Accumulated Costs	15,143,754	5	15,552	3,765,369	3,867	15
16	33	Real Estate Taxes	Accumulated Costs	15,143,754	5	92	3,765,369	23	16
17	34	Building Rent	Accumulated Costs	15,143,754	5	33,298	3,765,369	8,279	17
18	34	Rental - Storage Unit	Accumulated Costs	15,143,754	5	1,335	3,765,369	332	18
19	35	Equipment Rental	Accumulated Costs	15,143,754	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

Facility Name & ID Number

Aviston Countryside Manor

0056333

Report Period Beginning:

03/01/2020

Ending:

12/31/2020

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		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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	30,996	2
3. Under or (over) accrual (line 2 minus line 1).		\$	30,996	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	30,996	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	36,004	8
	2016	36,593	9
	2017	36,366	10
	2018	37,195	11
	2019	33,986	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

A. Summary of Real Estate Tax Cost

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.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-05-24-105-049</u>	<u>Sec24Twp2NRng5WPTSWNW 3.34/</u>	\$ <u>33,302.52</u>	\$ <u>33,302.52</u>
2. <u>05-05-24-105-018</u>	<u>Sec24Twp2NRng5WPTSWNW .63A</u>	\$ <u>683.86</u>	\$ <u>683.86</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>33,986.38</u></u>	\$ <u><u>33,986.38</u></u>

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Aviston Countryside Manor

0056333

Report Period Beginning:

03/01/2020 Ending:

12/31/2020

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for row numbers 1, 2, 3. Row 3 is shaded and labeled 'TOTALS'.

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	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				\$	\$		\$	\$	\$
5									
6									
7									
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									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

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

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		\$	\$		\$	\$	\$	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.

Facility Name & ID Number Aviston Countryside Manor

0056333

Report Period Beginning:

03/01/2020

Ending:

12/31/2020

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

Facility Name & ID Number Aviston Countryside Manor

0056333

Report Period Beginning: 03/01/2020

Ending: 12/31/2020

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:	<u>1988</u>	<u>97</u>	<u>03/01/2020</u>	\$ <u>378,537</u>	<u>15</u>		<u>3</u>
4	Additions							<u>4</u>
5								<u>5</u>
6								<u>6</u>
7	TOTAL		<u>97</u>		\$ <u>378,537</u>			<u>7</u>

10. Effective dates of current rental agreement:

Beginning 03/01/2020

Ending 02/28/2035

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2021</u>	\$ <u>461,816</u>
13.	<u>12/31/2022</u>	\$ <u>471,052</u>
14.	<u>12/31/2023</u>	\$ <u>480,473</u>

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	<u>Section N/A</u>		\$ _____	\$ _____	<u>17</u>
18					<u>18</u>
19					<u>19</u>
20					<u>20</u>
21	TOTAL		\$ _____	\$ _____	<u>21</u>

* 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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.)

	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):									13
14	TOTAL			\$		\$ 364,865	\$ 102,462		\$ 467,327	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Countryside Manor

0056333

Report Period Beginning: 03/01/2020

Ending:

12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

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

		1	2	
		Operating	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): <u>Deposits</u>	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	2	
		Operating	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	<u>Accrued Expenses</u>	21,794		36
37	<u>Deferred Revenue - CARES Funds</u>	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	<u>Related Parties</u>	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

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	Miscellaneous	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

Facility Name & ID Number Aviston Countryside Manor

0056333

Report Period Beginning: 03/01/2020

Ending: 12/31/2020

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	Ownership %	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 (Indicate # of checks performed _____)	1,915	
				Employee Health Insurance	37,389	Patient Background Checks		
				Employee Meals		Public Relations	1,869	
				Illinois Municipal Retirement Fund (IMRF)*		IHCA Dues	4,924	
				Retirement Plan	2,215	Subscriptions	2,142	
				Employee Relations	1,576	Misc Licenses & Fees	4,088	
				Related Party Allocation	14,460	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) (List each licensed administrator separately.)			\$ 60,956			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 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	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 230,600				In-State Travel	168
C. Professional Services							Related Party allocation	4,268
Vendor/Payee	Type		Amount				Food Service certification	331
Paycom Payroll	Payroll Services		\$ 20,673				Seminar Expense	
Old Second National Bank	Legal Fees		9,800				RELIAS	3,043
							IHCA	750
							OPTUM 360	124
							Entertainment Expense ()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 30,473	TOTAL		\$	TOTAL	\$ 8,684

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

