		FOR BHF USE			

LL1

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

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

I. IDPH License ID Number: 0056341

Facility Name: Mount Vernon Cntryside Manor

Address: 606 East IL Hwy 15 (Number) Mount Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: 618-242-1800 **Fax #** 618-242-9080

HFS ID Number:

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

Type of Ownership:

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

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)	(Date)
	(Type or Print Name)	Jason Mills
	(Title)	Chief Financial Officer
Paid Preparer	(Signed)	See Accountant's Preparation Report (Date)
	(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

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller Telephone Number: (618) 465-7717
Email Address:

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Mount Vernon Cntryside Manor # 0056341 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	33	Skilled (SNF)	33	10,098	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	17,748	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	91	TOTALS	91	27,846	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			3,487	3,487	8
9	SNF/PED					9
10	ICF	13,599	4,653		18,252	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,599	4,653	3,487	21,739	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.07%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/09/1990

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

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 32 and days of care provided 3,436

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number: Mount Vernon Cntryside Manor # 0056341 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 Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	180,826	7,773	6,753	195,352		195,352		195,352			1
2	Food Purchase		126,365		126,365		126,365		126,365			2
3	Housekeeping	92,092	6,248		98,340		98,340		98,340			3
4	Laundry	81,939	10,968		92,907		92,907		92,907			4
5	Heat and Other Utilities			72,120	72,120		72,120	(5,409)	66,711			5
6	Maintenance	91,328	34,431	31,852	157,611		157,611	2,232	159,843			6
7	Other (specify):* Waste Removal			9,254	9,254		9,254		9,254			7
8	**TOTAL General Services**	446,185	185,785	119,979	751,949		751,949	(3,177)	748,772			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000		8,000			9
10	Nursing and Medical Records	1,623,245	124,235	2,133	1,749,613		1,749,613	45,017	1,794,630			10
10a	Therapy		53		53		53		53			10a
11	Activities	34,898	1,416	1,267	37,581		37,581	(147)	37,434			11
12	Social Services	47,514		2,528	50,042		50,042		50,042			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,705,657	125,704	13,928	1,845,289		1,845,289	44,870	1,890,159			16
	C. General Administration											
17	Administrative	80,349		265,150	345,499		345,499	(246,023)	99,476			17
18	Directors Fees											18
19	Professional Services			24,641	24,641		24,641	18,063	42,704			19
20	Dues, Fees, Subscriptions & Promotions			20,427	20,427		20,427	8,322	28,749			20
21	Clerical & General Office Expenses	36,722	5,035	64,113	105,870		105,870	165,486	271,356			21
22	Employee Benefits & Payroll Taxes			304,802	304,802		304,802	18,785	323,587			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,966	4,966		4,966	5,545	10,511			24
25	Other Admin. Staff Transportation			6,216	6,216		6,216	2,391	8,607			25
26	Insurance-Prop.Liab.Malpractice			53,095	53,095		53,095	17,216	70,311			26
27	Other (specify):*											27
28	**TOTAL General Administration**	117,071	5,035	743,410	865,516		865,516	(10,215)	855,301			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,268,913	316,524	877,317	3,462,754		3,462,754	31,478	3,494,232			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 Mount Vernon Cntryside Manor #0056341 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,541	1,541		1,541	4,310	5,851			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							5,020	5,020			32
33	Real Estate Taxes			110,232	110,232		110,232	30	110,262			33
34	Rent-Facility & Grounds			872,591	872,591		872,591	11,187	883,778			34
35	Rent-Equipment & Vehicles							747	747			35
36	Other (specify):*											36
37	**TOTAL Ownership**			984,364	984,364		984,364	21,294	1,005,658			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		114,587	442,728	557,315		557,315		557,315			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			155,856	155,856		155,856		155,856			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		114,587	598,584	713,171		713,171		713,171			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,268,913	431,111	2,460,265	5,160,289		5,160,289	52,772	5,213,061			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 Mount Vernon Cntryside Manor # 0056341 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.)

	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	(147)	11		4
5	Telephone, TV & Radio in Resident Rooms	(6,941)	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	(4)	32		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	(2,288)	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	(5,271)	20		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (14,651)		$	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)	67,423	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 67,423		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 52,772		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

Mount Vernon Cntryside Manor

ID# 0056341

Report Period Beginning: 03/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lobbying/PAC Dues	$ (2,078)	20	1
2	Overaccrual of IDPH License	(3,193)	20	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
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,271)		49

Facility Name & ID Number Mount Vernon Cntryside Manor # 0056341 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

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 Aviston SNF	Aviston	Palladian Mgmt - King	O'Fallon	Mgmt Company
		Palladian Taylorville SNF	Taylorville	Palladian Mt. Vernon /	Mt. Vernon	Asstd Liv/MemCare
		Helia Healthcare of Belleville	Belleville	Palladian Taylorville A	Taylorville	Assisted 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. [X] YES [ ] NO

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	See Schedule VIII	$	Palladian Management	0.00%	$ 1,532	$ 1,532	1
2	V	6	See Schedule VIII		Palladian Management	0.00%	2,232	2,232	2
3	V	10	See Schedule VIII		Palladian Management	0.00%	45,017	45,017	3
4	V	17	See Schedule VIII	265,150	Palladian Management	0.00%	19,127	(246,023)	4
5	V	19	See Schedule VIII		Palladian Management	0.00%	18,063	18,063	5
6	V	20	See Schedule VIII		Palladian Management	0.00%	15,881	15,881	6
7	V	21	See Schedule VIII		Palladian Management	0.00%	165,486	165,486	7
8	V	22	See Schedule VIII		Palladian Management	0.00%	18,785	18,785	8
9	V	24	See Schedule VIII		Palladian Management	0.00%	5,545	5,545	9
10	V	25	See Schedule VIII		Palladian Management	0.00%	2,391	2,391	10
11	V	26	See Schedule VIII		Palladian Management	0.00%	17,216	17,216	11
12	V	30	See Schedule VIII		Palladian Management	0.00%	4,310	4,310	12
13	V	32	See Schedule VIII		Palladian Management	0.00%	5,024	5,024	13
14	Total			$ 265,150			$ 320,609	$ * 55,459	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mount Vernon Cntryside Manor # 0056341 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

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. [X] YES [ ] NO

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

	1	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%	$ 30	$ 30	15
16	V	34	See Schedule VIII		Palladian Management	0.00%	11,187	11,187	16
17	V	35	See Schedule VIII		Palladian Management	0.00%	747	747	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			$			$ 11,964	$ * 11,964	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mount Vernon Cntryside Manor # 0056341 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 Mount Vernon Cntryside Manor # 0056341 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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Stephen Miller	Owner	Administrative	100.00	387,301	2.35	4.70	Distribution	$ 19,127	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	$ 19,127		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 Mount Vernon Cntryside Manor # 0056341 Report Period Beginning: 03/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat & Other Utilities	Accumulated Costs	15,143,754	5	$ 4,744	$	4,891,645	$ 1,532	1
2	6	Maintenance	Accumulated Costs	15,143,754	5	6,910		4,891,645	2,232	2
3	10	Nursing & Med Rec - Salaries	Accumulated Costs	15,143,754	5	136,053	136,053	4,891,645	43,947	3
4	10	Nursing & Med Rec - Salaries	Accumulated Costs	15,143,754	5	3,313		4,891,645	1,070	4
5	17	Owners Compensation	Accumulated Costs	15,143,754	5	59,215		4,891,645	19,127	5
6	19	Professional Services	Accumulated Costs	15,143,754	5	55,919		4,891,645	18,063	6
7	20	Dues & Subscriptions	Accumulated Costs	15,143,754	5	49,166		4,891,645	15,881	7
8	21	Clerical & Office - Salaries	Accumulated Costs	15,143,754	5	392,257	392,257	4,891,645	126,705	8
9	21	Clerical & Office - Supplies	Accumulated Costs	15,143,754	5	120,060		4,891,645	38,781	9
10	22	Employee Benefits	Accumulated Costs	15,143,754	5	58,155		4,891,645	18,785	10
11	24	Travel & Seminar	Accumulated Costs	15,143,754	5	17,167		4,891,645	5,545	11
12	25	Other Admin Transportation	Accumulated Costs	15,143,754	5	7,401		4,891,645	2,391	12
13	26	Insurance	Accumulated Costs	15,143,754	5	53,298		4,891,645	17,216	13
14	30	Depreciation	Accumulated Costs	15,143,754	5	13,344		4,891,645	4,310	14
15	32	Interest	Accumulated Costs	15,143,754	5	15,552		4,891,645	5,024	15
16	33	Real Estate Taxes	Accumulated Costs	15,143,754	5	92		4,891,645	30	16
17	34	Building Rent	Accumulated Costs	15,143,754	5	33,298		4,891,645	10,756	17
18	34	Rental - Storage Unit	Accumulated Costs	15,143,754	5	1,335		4,891,645	431	18
19	35	Equipment Rental	Accumulated Costs	15,143,754	5	2,313		4,891,645	747	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,029,592	$ 528,310		$ 332,573	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mount Vernon Cntryside Manor # 0056341 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	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							5,024	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 5,024	9
	B. Non-Facility Related*											
10	Interest Income offset										(4)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4)	14
15	TOTALS (line 9+line14)						$	$			$ 5,020	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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 & ID Number Mount Vernon Cntryside Manor # 0056341 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

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.

Line	Description	Amount	
1	1. Real Estate Tax accrual used on 2019 report.	$	1
2	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.)	$ 110,232	2
3	3. Under or (over) accrual (line 2 minus line 1).	$ 110,232	3
4	4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5	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	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	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 110,232	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	142,363	8
2016	144,899	9
2017	148,067	10
2018	160,056	11
2019	170,773	12

FOR BHF USE ONLY

Line	Description	Amount	Line
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 Mount Vernon Cntryside Manor COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0056341

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-28-376-013	2S 3E LMC Plaza Lots 1-5	$ 282,269.16	$ 170,772.84
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 282,269.16	$ 170,772.84

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? X YES ____ 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 Mount Vernon Cntryside Manor # 0056341 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,000 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. [X] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).
Palladian Mt. Vernon ALF, LLC is a 48 unit, 36,000 square foot retirement center located on the property adjacent to Palladian Mt. Vernon SNF, LLC.

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

1. Total Amount Incurred: 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

Facility Name & ID Number Mount Vernon Cntryside Manor # 0056341 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New office build out - Home Office			2011	6,392		20	339	339	3,199	9
10	Conference room chair rail & paint - Home Office			2012	72		20			72	10
11	AC Unit in Server Room - Home Office			2018	496		20	25	25	62	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 Mount Vernon Cntryside Manor # 0056341 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)		$ 6,960	$		$ 364	$ 364	$ 3,333	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Mount Vernon Cntryside Manor # 0056341 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	$ 7,500	$	$ 2,040	$ 2,040		$ 4,244	71
72	Current Year Purchases	22,737	1,541	3,447	1,906		3,447	72
73	Fully Depreciated Assets	2,261					2,261	73
74								74
75	TOTALS	$ 32,498	$ 1,541	$ 5,487	$ 3,946		$ 9,952	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	Section N/A			$	$	$	$		$	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)	$ 39,458	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,541	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 5,851	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,310	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 13,285	85

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

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

G. Construction-in-Progress

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number: Mount Vernon Cntryside Manor # 0056341 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. [X] 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:	1990	91	03/01/2020	$ 872,591	15		3
4	Additions							4
5								5
6		Related Party Allocation			11,187			6
7	TOTAL		91		$ 883,778 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 0
This amount was calculated by dividing the total amount to be amortized by the length of the lease . 0

9. Option to Buy: [ ] YES [ ] NO Terms: ______ *

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.	12/31/2021	$ 1,064,561
13.	12/31/2022	$ 1,085,853
14.	12/31/2023	$ 1,107,570

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: $ ______ Description: ______
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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		# of prescrpts				112,750		112,750	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen						1,837		1,837	12
13	Other (specify): Lab, X-Rays, Therapies, Ambulance					442,728			442,728	13
14	TOTAL			$		$ 442,728	$ 114,587		$ 557,315	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 Mount Vernon Cntryside Manor # 0056341 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 342,802	$	1
2	Cash-Patient Deposits	280		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 33,067)	563,855		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,048		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 912,985	$	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	7,927		16
17	Accumulated Depreciation (book methods)	(1,541)		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	325,015		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 331,401	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,244,386	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 121,800	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	270		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,450		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	20,059		36
37	Deferred Revenue - CARES Funds	124,540		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 410,119	$	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	Due to Related Parties	849,695		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 849,695	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,259,814	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (15,428)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,244,386	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name & ID Number **Mount Vernon Cntryside Manor** **# 0056341** **Report Period Beginning: 03/01/2020** **Ending: 12/31/2020**

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)	(15,428)	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)**	$ (15,428)	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)**	$ (15,428)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mount Vernon Cntryside Manor # 0056341 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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,797,334	1
2	Discounts and Allowances for all Levels	(887,671)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,909,663	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	234,780	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 234,780	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***	4	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous	267	28
28a	Vending Income	147	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 414	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,144,861	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	751,949	31
32	Health Care	1,845,289	32
33	General Administration	865,516	33
	B. Capital Expense		
34	Ownership	984,364	34
	C. Ancillary Expense		
35	Special Cost Centers	557,315	35
36	Provider Participation Fee	155,856	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,160,289	40
41	**Income before Income Taxes (line 30 minus line 40)****	(15,428)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (15,428)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,211,670	44
45	Private Pay - Net Inpatient Revenue	844,241	45
46	Medicare - Net Inpatient Revenue	1,826,678	46
47	Other-(specify) Managed Care	27,074	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,909,663	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 Mount Vernon Cntryside Manor # 0056341 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	2,311	2,399	$ 85,197	$ 35.51	1
2	Assistant Director of Nursing	2,133	2,199	60,542	27.53	2
3	Registered Nurses	10,409	10,699	269,307	25.17	3
4	Licensed Practical Nurses	15,605	16,217	351,756	21.69	4
5	CNAs & Orderlies	60,356	62,231	825,280	13.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,081	3,220	34,898	10.84	9
10	Activity Assistants					10
11	Social Service Workers	2,896	3,086	47,514	15.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,256	14,846	180,826	12.18	15
16	Dishwashers					16
17	Maintenance Workers	3,917	4,056	91,328	22.52	17
18	Housekeepers	8,899	9,203	92,092	10.01	18
19	Laundry	7,797	8,069	81,939	10.15	19
20	Administrator	1,830	1,870	80,349	42.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,878	1,989	36,722	18.46	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	2,043	2,215	31,163	14.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,411	142,299	$ 2,268,913 *	$ 15.94	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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		$ 6,753	1, 3	35
36	Medical Director		8,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,133	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		1,267	11, 3	44
45	Social Service Consultant		2,528	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,681		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number: Mount Vernon Cntryside Manor # 0056341 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tyger Downen	Administrator	0	$ 80,349
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 80,349

B. Administrative - Other

Description	Amount
Palladian Management - King	$ 265,150
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 265,150

C. Professional Services

Vendor/Payee	Type	Amount
PayCom	Payroll processing services	$ 24,641
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 24,641

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,460
Unemployment Compensation Insurance	43,252
FICA Taxes	162,793
Employee Health Insurance	62,503
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan contribution	972
Employee Relations	822
Related Party Allocation	18,785
TOTAL (agree to Schedule V, line 22, col.8)	$ 323,587

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	974
Health Care Worker Background Check	2,063
(Indicate # of checks performed)	
Patient Background Checks	
IHCA Dues	4,620
Misc Licenses & Fees	2,764
Promotional Advertising	2,288
Misc Dues	457
Related Party Allocation	15,881
Less: Public Relations Expense	( )
Non-allowable advertising	(2,288)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,749

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	267
Related Party Allocation	5,545
Seminar Expense	
RELIAS	3,687
OPTUM 360	262
IHCA	750
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,511

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mount Vernon Cntryside Manor # 0056341 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $4,620**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **N/A**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **155,856**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **None** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.