		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: 0056325

Facility Name: Taylorville Care Center

Address: 600 South Houston (Number) Taylorville (City) 62568 (Zip Code)

County: Christian

Telephone Number: 217-824-9636 **Fax #** 217-824-8437

HFS ID Number:

Date of Initial License for Current Owners: 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

Facility Name & ID Number Taylorville Care Center # 0056325 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	98	Skilled (SNF)	98	29,988	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	29,988	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	12,450	4,722	1,880	19,052	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,450	4,722	1,880	19,052	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.53%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 08/01/1984

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 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 24 and days of care provided 1,581

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: Taylorville Care Center # 0056325 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	150,455	8,477	6,056	164,988		164,988		164,988			1
2	Food Purchase		123,776		123,776		123,776		123,776			2
3	Housekeeping	103,903	7,375		111,278		111,278		111,278			3
4	Laundry	57,080	14,046		71,126		71,126		71,126			4
5	Heat and Other Utilities			81,019	81,019		81,019	(6,925)	74,094			5
6	Maintenance	65,676	17,364	10,115	93,155		93,155	1,712	94,867			6
7	Other (specify):* Waste Removal			3,457	3,457		3,457		3,457			7
8	**TOTAL General Services**	377,114	171,038	100,647	648,799		648,799	(5,213)	643,586			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000		8,000			9
10	Nursing and Medical Records	1,102,951	63,640	16,386	1,182,977		1,182,977	34,524	1,217,501			10
10a	Therapy	105,103			105,103		105,103		105,103			10a
11	Activities	56,006	2,719	175	58,900		58,900		58,900			11
12	Social Services	27,065		3,771	30,836		30,836		30,836			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,291,125	66,359	28,332	1,385,816		1,385,816	34,524	1,420,340			16
	C. General Administration											
17	Administrative	81,557		219,050	300,607		300,607	(204,381)	96,226			17
18	Directors Fees											18
19	Professional Services			19,520	19,520		19,520	13,852	33,372			19
20	Dues, Fees, Subscriptions & Promotions			41,358	41,358		41,358	(11,786)	29,572			20
21	Clerical & General Office Expenses	34,554	6,669	70,819	112,042		112,042	126,910	238,952			21
22	Employee Benefits & Payroll Taxes			235,220	235,220		235,220	14,406	249,626			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,581	6,581		6,581	4,253	10,834			24
25	Other Admin. Staff Transportation			2,011	2,011		2,011	1,833	3,844			25
26	Insurance-Prop.Liab.Malpractice			78,195	78,195		78,195	13,203	91,398			26
27	Other (specify):*											27
28	**TOTAL General Administration**	116,111	6,669	672,754	795,534		795,534	(41,710)	753,824			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,784,350	244,066	801,733	2,830,149		2,830,149	(12,399)	2,817,750			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 **Taylorville Care Center** **#0056325** **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			2,135	2,135		2,135	3,306	5,441			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							3,852	3,852			32
33	Real Estate Taxes			50,926	50,926		50,926	23	50,949			33
34	Rent-Facility & Grounds			451,637	451,637		451,637	8,579	460,216			34
35	Rent-Equipment & Vehicles							573	573			35
36	Other (specify):*											36
37	**TOTAL Ownership**			504,698	504,698		504,698	16,333	521,031			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,257	453,026	503,283		503,283		503,283			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			156,233	156,233		156,233		156,233			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		50,257	609,259	659,516		659,516		659,516			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,784,350	294,323	1,915,690	3,994,363		3,994,363	3,934	3,998,297			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 Taylorville Care Center # 0056325 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				4
5	Telephone, TV & Radio in Resident Rooms	(8,100)	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	(379)	20		17
18	Fines and Penalties	(17,680)	20		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	(3,688)	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	(2,218)	20		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (32,065)		$	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)	35,999		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 35,999		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 3,934		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

STATE OF ILLINOIS

Taylorville Care Center

ID# 0056325

Report Period Beginning: 03/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Lobbying/PAC Dues	$ (2,218)	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
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	(2,218)		49

Facility Name & ID Number Taylorville Care Center # 0056325 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 Mt. Vernon SNF	Mt. Vernon	Palladian Mt. Vernon /	Mt. Vernon	Asstd Liv/MemCare
		Helia Healthcare of Belleville	Belleville	Palladian Taylorville A	Taylorville	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. [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)	
1	V	5	See Schedule VIII	$	Palladian Management	0.00%	$ 1,175	$ 1,175	1
2	V	6	See Schedule VIII		Palladian Management	0.00%	1,712	1,712	2
3	V	10	See Schedule VIII		Palladian Management	0.00%	34,524	34,524	3
4	V	17	See Schedule VIII	219,050	Palladian Management	0.00%	14,669	(204,381)	4
5	V	19	See Schedule VIII		Palladian Management	0.00%	13,852	13,852	5
6	V	20	See Schedule VIII		Palladian Management	0.00%	12,179	12,179	6
7	V	21	See Schedule VIII		Palladian Management	0.00%	126,910	126,910	7
8	V	22	See Schedule VIII		Palladian Management	0.00%	14,406	14,406	8
9	V	24	See Schedule VIII		Palladian Management	0.00%	4,253	4,253	9
10	V	25	See Schedule VIII		Palladian Management	0.00%	1,833	1,833	10
11	V	26	See Schedule VIII		Palladian Management	0.00%	13,203	13,203	11
12	V	30	See Schedule VIII		Palladian Management	0.00%	3,306	3,306	12
13	V	32	See Schedule VIII		Palladian Management	0.00%	3,852	3,852	13
14	Total			$ 219,050			$ 245,874	$ * 26,824	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Taylorville Care Center # 0056325 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%	$ 23	$ 23	15
16	V	34	See Schedule VIII		Palladian Management	0.00%	8,579	8,579	16
17	V	35	See Schedule VIII		Palladian Management	0.00%	573	573	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			$			$ 9,175	$ * 9,175	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Taylorville Care Center # 0056325 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 Taylorville Care Center # 0056325 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	391,759	1.8	3.60	Distribution	$ 14,669	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	$ 14,669		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 Taylorville Care Center # 0056325 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 [X] NO [ ]

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

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	$	3,751,364	$ 1,175	1
2	6	Maintenance	Accumulated Costs	15,143,754	5	6,910		3,751,364	1,712	2
3	10	Nursing & Med Rec - Salaries	Accumulated Costs	15,143,754	5	136,053	136,053	3,751,364	33,703	3
4	10	Nursing & Med Rec - Supplies	Accumulated Costs	15,143,754	5	3,313		3,751,364	821	4
5	17	Owners Compensation	Accumulated Costs	15,143,754	5	59,215		3,751,364	14,669	5
6	19	Professional Fees	Accumulated Costs	15,143,754	5	55,919		3,751,364	13,852	6
7	20	Dues & Subscriptions	Accumulated Costs	15,143,754	5	49,166		3,751,364	12,179	7
8	21	Clerical & Office - Salaries	Accumulated Costs	15,143,754	5	392,257	392,257	3,751,364	97,169	8
9	21	Clerical & Office - Supplies	Accumulated Costs	15,143,754	5	120,060		3,751,364	29,741	9
10	22	Employee Benefits	Accumulated Costs	15,143,754	5	58,155		3,751,364	14,406	10
11	24	Travel & Seminar	Accumulated Costs	15,143,754	5	17,167		3,751,364	4,253	11
12	25	Other Admin Transportation	Accumulated Costs	15,143,754	5	7,401		3,751,364	1,833	12
13	26	Insurance	Accumulated Costs	15,143,754	5	53,298		3,751,364	13,203	13
14	30	Depreciation	Accumulated Costs	15,143,754	5	13,344		3,751,364	3,306	14
15	32	Interest	Accumulated Costs	15,143,754	5	15,552		3,751,364	3,852	15
16	33	Real Estate Taxes	Accumulated Costs	15,143,754	5	92		3,751,364	23	16
17	34	Building Rent	Accumulated Costs	15,143,754	5	33,298		3,751,364	8,248	17
18	34	Rental - Storage Unit	Accumulated Costs	15,143,754	5	1,335		3,751,364	331	18
19	35	Equipment Rental	Accumulated Costs	15,143,754	5	2,313		3,751,364	573	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,029,592	$ 528,310		$ 255,049	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Taylorville Care Center # 0056325 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							3,852	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 3,852	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 3,852	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 Taylorville Care Center # 0056325 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.

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.)	$	50,926	2
3. Under or (over) accrual (line 2 minus line 1).	$	50,926	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.	$	50,926	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	48,613	8
	2016	48,612	9
	2017	53,677	10
	2018	55,150	11
	2019	56,562	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 Taylorville Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0056325

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)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	17-13-28-401-005-00	Cheney's Add Lts 1-6 Blk 3 &	$ 56,561.96	$ 56,561.96
2.		Lts 1-6 Blk4 & OL 1 & Vac	$	$
3.		Austin St & Alley	$	$
4.		282x652 13-28-G	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 56,561.96	$ 56,561.96

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,610 B. General Construction Type: Exterior Brick Frame Non-comb sprinkle Number of Stories 1

C. Does the Operating Entity? [ ] (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? [ ] (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).

Taylorville Estates is a 49 unit, 27,945 sq ft retirement center which is located on the property adjacent to Taylorville Care Center, Inc.

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

1. Total Amount Incurred:
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 Taylorville Care Center # 0056325 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	4,902		20	260	260	2,454	9
10	Conference room chair rail & paint - Home Office			2012	55		20			55	10
11	AC Unit in Server Room - Home Office			2018	380		20	19	19	48	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 Taylorville Care Center # 0056325 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,337	$		$ 279	$ 279	$ 2,557	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Taylorville Care Center # 0056325 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	$ 5,752	$	$ 1,565	$ 1,565		$ 3,255	71
72	Current Year Purchases	22,340	2,135	3,597	1,462		3,597	72
73	Fully Depreciated Assets	1,734					1,734	73
74								74
75	TOTALS	$ 29,826	$ 2,135	$ 5,162	$ 3,027		$ 8,586	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)	$ 35,163	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 2,135	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 5,441	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,306	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 11,143	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 Taylorville Care Center # 0056325 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:	1974	98	03/01/2020	$ 451,637	15		3
4	Additions							4
5								5
6	Palladian Management Allocation				8,579			6
7	TOTAL		98		$ 460,216 **			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 0
   by the length of the lease .
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	$ 550,997
13.	12/31/2022	$ 562,017
14.	12/31/2023	$ 573,258

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

15. Is Movable equipment rental included in building rental? [N/A] 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

Facility Name & ID Number Taylorville Care Center # 0056325 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				49,776		49,776	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen & Wound Care						481		481	12
13	Other (specify): Lab, X-Rays, Therapies, Ambulance					453,026			453,026	13
14	TOTAL			$		$ 453,026	$ 50,257		$ 503,283	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 Taylorville Care Center # 0056325 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	$ 645,128	$	1
2	Cash-Patient Deposits	1,159		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	418,113		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	849		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,065,249	$	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	10,982		16
17	Accumulated Depreciation (book methods)	(2,135)		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	223,321		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 232,168	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,297,417	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 110,180	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,818		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,340		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	71,971		36
37	Deferred Revenue - CARES Funds	139,179		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 408,488	$	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	633,426		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 633,426	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,041,914	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 255,503	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,297,417	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name & ID Number Taylorville Care Center # 0056325 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)	255,503	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)**	$ 255,503	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)**	$ 255,503	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Taylorville Care Center # 0056325 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	$ 4,291,047	1
2	Discounts and Allowances for all Levels	(479,794)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,811,253	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	438,249	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 438,249	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***	1	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous	363	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 363	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,249,866	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	648,799	31
32	Health Care	1,385,816	32
33	General Administration	795,534	33
	B. Capital Expense		
34	Ownership	504,698	34
	C. Ancillary Expense		
35	Special Cost Centers	503,283	35
36	Provider Participation Fee	156,233	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,994,363	40
41	**Income before Income Taxes (line 30 minus line 40)****	255,503	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 255,503	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,000,985	44
45	Private Pay - Net Inpatient Revenue	854,953	45
46	Medicare - Net Inpatient Revenue	815,206	46
47	Other-(specify) Managed Care	140,109	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,811,253	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 Taylorville Care Center # 0056325 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	1,563	1,676	$ 59,130	$ 35.28	1
2	Assistant Director of Nursing	1,163	1,316	43,614	33.14	2
3	Registered Nurses	2,124	2,138	54,219	25.36	3
4	Licensed Practical Nurses	16,867	17,708	414,078	23.38	4
5	CNAs & Orderlies	34,958	35,749	506,259	14.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,759	7,130	105,103	14.74	8
9	Activity Director					9
10	Activity Assistants	4,532	4,736	56,006	11.83	10
11	Social Service Workers	1,349	1,431	27,065	18.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,820	13,244	150,455	11.36	15
16	Dishwashers					16
17	Maintenance Workers	3,610	3,806	65,676	17.26	17
18	Housekeepers	9,154	9,422	103,903	11.03	18
19	Laundry	5,054	5,085	57,080	11.23	19
20	Administrator	1,825	1,907	81,557	42.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,797	1,945	34,554	17.77	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	1,483	1,591	25,651	16.12	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,058	108,884	$ 1,784,350 *	$ 16.39	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		$ 6,056	1, 3	35
36	Medical Director		8,000	9, 3	36
37	Medical Records Consultant		1,689	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,830	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				44
45	Social Service Consultant		3,771	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,346		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	408	12,866	10, 3	52
53	TOTAL (lines 50 - 52)	408	$ 12,866		53

Facility Name & ID Number Taylorville Care Center # 0056325 Report Period Beginning: 03/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rhonda Hancock	Administrator	0	$ 81,557
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 81,557

B. Administrative - Other

Description	Amount
Palladian Management	$ 219,050
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 219,050

C. Professional Services

Vendor/Payee	Type	Amount
PayCom	Payroll processing services	$ 19,520
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 19,520

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,755
Unemployment Compensation Insurance	39,371
FICA Taxes	130,000
Employee Health Insurance	34,550
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Fund contribution	1,526
Employee Relations	3,018
Related Party Allocation	14,406
TOTAL (agree to Schedule V, line 22, col.8)	$ 249,626

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed ____)	2,260
Patient Background Checks	
IHCA Dues	4,975
Misc Dues & Subscriptions	937
Misc Licenses & Fees	7,231
Promotional Advertising	3,688
Related Party Allocation	12,179
Less: Public Relations Expense	( )
Non-allowable advertising	(3,688)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,572

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,139
Related Party Allocation	4,253
Seminar Expense	
RELIAS	3,687
Other Seminar	1,755
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,834

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

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 - $4,975**

(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. $ **156,233**
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. $ **None**

(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 - None**
Attach invoices and a summary of services for all architect and appraisal fees.