

		FOR BHF USE					

LL 1

**2018**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2018)**

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

**I. IDPH License ID Number:** 0033407

**Facility Name:** Aviston Countryside Manor, Inc.

**Address:** 450 West 1st Street Aviston 62216  
 Number City Zip Code

**County:** Clinton

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

**HFS ID Number:** \_\_\_\_\_

**Date of Initial License for Current Owners:** 2/23/1988

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Amy Elik, Chief Financial Officer **Telephone Number:** 618-327-3064  
**Email Address:** \_\_\_\_\_

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2018 to 12/31/18 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____
	(Type or Print Name) <u>Amy Elik</u>
<b>Paid Preparer</b>	(Title) <u>Chief Financial Officer</u>
	(Signed) _____ (Date) _____
	(Print Name and Title) <u>N/A</u>
	(Firm Name & Address) _____
	(Telephone) ( ) Fax # ( )

**MAIL TO: BUREAU OF HEALTH FINANCE**  
**ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES**  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Aviston Countryside Manor, Inc.

# 0033407 Report Period Beginning: 1/1/2018 Ending: 12/31/18

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>34</u>	Skilled (SNF)	<u>34</u>	<u>12,410</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>63</u>	Intermediate (ICF)	<u>63</u>	<u>22,995</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>35,405</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>3,094</u>	<u>3,094</u>	8
9	SNF/PED					9
10	ICF	<u>7,858</u>	<u>10,643</u>	<u>2,016</u>	<u>20,517</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,858</u>	<u>10,643</u>	<u>5,110</u>	<u>23,611</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.69%

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)  
Daycare

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 2/23/1988

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 32 and days of care provided 2,452

Medicare Intermediary CGS

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name &amp; ID Number

Aviston Countryside Manor, Inc.

# 0033407

Report Period Beginning:

1/1/2018

Ending:

12/31/18

## 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					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	175,634	14,989	6,102	196,725		196,725		196,725		1
2	Food Purchase		133,736		133,736		133,736	(1,196)	132,540		2
3	Housekeeping	114,299	9,680		123,979		123,979	4	123,983		3
4	Laundry	58,580	10,853		69,433		69,433		69,433		4
5	Heat and Other Utilities			110,697	110,697		110,697	(5,796)	104,901		5
6	Maintenance	39,041	47,276	14,324	100,641		100,641	693	101,334		6
7	Other (specify):* Sanitation			10,159	10,159		10,159	(2,560)	7,599		7
8	<b>TOTAL General Services</b>	387,554	216,534	141,282	745,370		745,370	(8,855)	736,515		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	1,396,342	68,692	36,713	1,501,747		1,501,747	(70)	1,501,677		10
10a	Therapy										10a
11	Activities	46,732	6,052	4,928	57,712	1,548	59,260	(80)	59,180		11
12	Social Services	33,197		3,096	36,293	(1,548)	34,745		34,745		12
13	CNA Training										13
14	Program Transportation		2,777		2,777		2,777		2,777		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,476,271	77,521	47,137	1,600,929		1,600,929	(150)	1,600,779		16
	<b>C. General Administration</b>										
17	Administrative	83,535	4,087	332,000	419,622	(1,629)	417,993	(177,590)	240,403		17
18	Directors Fees										18
19	Professional Services			17,343	17,343	1,629	18,972	(9,730)	9,242		19
20	Dues, Fees, Subscriptions & Promotions			52,199	52,199		52,199	(32,930)	19,269		20
21	Clerical & General Office Expenses	32,416	13,101	69,030	114,547		114,547	73,670	188,217		21
22	Employee Benefits & Payroll Taxes			242,830	242,830		242,830	14,279	257,109		22
23	Inservice Training & Education			3,815	3,815	(800)	3,015		3,015		23
24	Travel and Seminar					1,287	1,287	343	1,630		24
25	Other Admin. Staff Transportation			2,364	2,364	(487)	1,877	1,254	3,131		25
26	Insurance-Prop.Liab.Malpractice			42,985	42,985		42,985	838	43,823		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	115,951	17,188	762,566	895,705		895,705	(129,866)	765,839		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,979,776	311,243	950,985	3,242,004		3,242,004	(138,871)	3,103,133		29

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

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

Facility Name &amp; ID Number

Aviston Countryside Manor, Inc.

#0033407

Report Period Beginning:

1/1/2018

Ending:

12/31/18

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			105,559	105,559		105,559	5,845	111,404		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			35,466	35,466		35,466		35,466		33
34	Rent-Facility & Grounds							5,359	5,359		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			141,025	141,025		141,025	11,204	152,229		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		74,468	369,105	443,573		443,573	(294)	443,279		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			176,067	176,067		176,067		176,067		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		74,468	545,172	619,640		619,640	(294)	619,346		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,979,776	385,711	1,637,182	4,002,669		4,002,669	(127,961)	3,874,708		45

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

Aviston Countryside Manor, Inc.  
Reclassifications  
12/31/2018

Activities	Line 11	1,548
Social Services	Line 12	(1,548)
Reclass cost of activities consultant to correct line		
Inservice Training and Education	Line 23	(800)
Travel and Seminar	Line 24	800
Reclass seminar expenses to correct line		
Administrative	Line 17	(1,629)
Professional Services	Line 19	1,629
Reclass accounting fees to correct line		
Other Admin Staff Transportation	Line 25	(487)
Travel and Seminar	Line 24	487
Reclass seminar travel to correct line		

**FOR LINES 1 THRU 28 AND 31 THRU 33, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINES 29 OR 35 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.**

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Aviston Countryside Manor, Inc.

# 0033407

Report Period Beginning: 1/1/2018

Ending:

12/31/18

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,606)	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	(1,015)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,196)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,458)	17		19
20	Contributions	(1,235)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,781)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,735)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,144)	20		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,067)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (61,237)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(66,724)	Var.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (66,724)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (127,961)		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.

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

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.  
 The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS

Page 5A

Aviston Countryside Manor, Inc.

ID# 0033407

Report Period Beginning: 1/1/2018

Ending: 12/31/18

		Amount	Sch. V Line Reference	
1	offset class action lawsuit settlement received	\$ (294)	39	1
2	offset class action lawsuit settlement received	(2,560)	7	2
3	offset DVD/memorial sales	(80)	11	3
4	offset medical records reimbursements	(70)	10	4
5	eliminate chamber of commerce dues	(125)	20	5
6	eliminate lobbying portion of IHCA dues	(1,938)	20	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	<b>Total</b>	(5,067)		49

Sch V	Adj. Summary
Line 1	0
Line 2	(1,196)
Line 3	0
Line 4	0
Line 5	(6,606)
Line 6	0
Line 7	(2,560)
Line 8	(10,362)
Line 9	0
Line 10	(70)
Line 10a	0
Line 11	(80)
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	(150)
Line 17	(2,458)
Line 18	0
Line 19	(13,781)
Line 20	(33,177)
Line 21	0
Line 22	0
Line 23	0
Line 24	0
Line 25	0
Line 26	0
Line 27	0
Line 28	(49,416)
Line 29	(59,928)
Line 30	(1,015)
Line 31	0
Line 32	0
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	(1,015)
Line 38	0
Line 39	(294)
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	(294)
Line 45	(61,237)

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aviston Countryside Manor, Inc.# 0033407

Report Period Beginning:

1/1/2018

Ending:

12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>A. General Services</b>												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2	Food Purchase	(1,196)	0	0	0	0	0	0	0	0	0	0	(1,196) 2
3	Housekeeping	0	4	0	0	0	0	0	0	0	0	0	4 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	(6,606)	810	0	0	0	0	0	0	0	0	0	(5,796) 5
6	Maintenance	0	693	0	0	0	0	0	0	0	0	0	693 6
7	Other (specify):*	(2,560)	0	0	0	0	0	0	0	0	0	0	(2,560) 7
8	<b>TOTAL General Services</b>	<b>(10,362)</b>	<b>1,507</b>	<b>0</b>	<b>(8,855) 8</b>								
	<b>B. Health Care and Programs</b>												
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	(70)	0	0	0	0	0	0	0	0	0	0	(70) 10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	(80)	0	0	0	0	0	0	0	0	0	0	(80) 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	<b>TOTAL Health Care and Programs</b>	<b>(150)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(150) 16</b>
	<b>C. General Administration</b>												
17	Administrative	(2,458)	(175,132)	0	0	0	0	0	0	0	0	0	(177,590) 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	(13,781)	4,051	0	0	0	0	0	0	0	0	0	(9,730) 19
20	Fees, Subscriptions & Promotions	(33,177)	247	0	0	0	0	0	0	0	0	0	(32,930) 20
21	Clerical & General Office Expenses	0	73,670	0	0	0	0	0	0	0	0	0	73,670 21
22	Employee Benefits & Payroll Taxes	0	14,279	0	0	0	0	0	0	0	0	0	14,279 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	0	343	0	0	0	0	0	0	0	0	0	343 24
25	Other Admin. Staff Transportation	0	1,254	0	0	0	0	0	0	0	0	0	1,254 25
26	Insurance-Prop.Liab.Malpractice	0	838	0	0	0	0	0	0	0	0	0	838 26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28	<b>TOTAL General Administration</b>	<b>(49,416)</b>	<b>(80,450)</b>	<b>0</b>	<b>(129,866) 28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(59,928)</b>	<b>(78,943)</b>	<b>0</b>	<b>(138,871) 29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aviston Countryside Manor, Inc.# 0033407

Report Period Beginning:

1/1/2018

Ending:

12/31/18

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	(1,015)	6,860	0	0	0	0	0	0	0	0	0	5,845 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	5,359	0	0	0	0	0	0	0	0	0	5,359 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(1,015)</b>	<b>12,219</b>	<b>0</b>	<b>11,204 37</b>								
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	(294)	0	0	0	0	0	0	0	0	0	0	(294) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>(294)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(294) 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(61,237)</b>	<b>(66,724)</b>	<b>0</b>	<b>(127,961) 45</b>								

Facility Name & ID Number Aviston Countryside Manor, Inc.

# 0033407

Report Period Beginning: 1/1/2018 Ending: 12/31/18

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
<a href="#">Denise King 2012 Exempt Trust</a>	20	<a href="#">Mt. Vernon Countryside Manor, Inc.</a>	<a href="#">Mt. Vernon, IL</a>	<a href="#">King Management Co.</a>	<a href="#">O'Fallon, IL</a>	<a href="#">Home Office</a>
<a href="#">Leslie Pedtke 2012 Exempt Trust</a>	20	<a href="#">Taylorville Care Center, Inc.</a>	<a href="#">Taylorville, IL</a>	<a href="#">Residential Living Ctr</a>	<a href="#">Mt. Vernon, IL</a>	<a href="#">Asstd Liv/Mem Care</a>
<a href="#">Keith King 2012 Exempt Trust</a>	20			<a href="#">Taylorville Estates</a>	<a href="#">Taylorville, IL</a>	<a href="#">Asstd Living</a>
<a href="#">Elizabeth Todorov 2012 Exempt Trust</a>	20			<a href="#">Trenton Village</a>	<a href="#">Trenton, IL</a>	<a href="#">Asstd Liv/Mem Care</a>
<a href="#">Michelle Hirschfeld 2012 Exempt Trust</a>	20					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	3 <a href="#">See Schedule VIII</a>	\$	<a href="#">King Management Company</a>	0.00%	\$ 4	\$ 4	1
2	V	5 <a href="#">See Schedule VIII</a>		<a href="#">King Management Company</a>	0.00%	810	810	2
3	V	6 <a href="#">See Schedule VIII</a>		<a href="#">King Management Company</a>	0.00%	693	693	3
4	V	17 <a href="#">See Schedule VIII</a>	332,000	<a href="#">King Management Company</a>	0.00%	156,868	(175,132)	4
5	V	19 <a href="#">See Schedule VIII</a>		<a href="#">King Management Company</a>	0.00%	4,051	4,051	5
6	V	20 <a href="#">See Schedule VIII</a>		<a href="#">King Management Company</a>	0.00%	247	247	6
7	V	21 <a href="#">See Schedule VIII</a>		<a href="#">King Management Company</a>	0.00%	73,670	73,670	7
8	V	22 <a href="#">See Schedule VIII</a>		<a href="#">King Management Company</a>	0.00%	14,279	14,279	8
9	V	24 <a href="#">See Schedule VIII</a>		<a href="#">King Management Company</a>	0.00%	343	343	9
10	V	25 <a href="#">See Schedule VIII</a>		<a href="#">King Management Company</a>	0.00%	1,254	1,254	10
11	V	26 <a href="#">See Schedule VIII</a>		<a href="#">King Management Company</a>	0.00%	838	838	11
12	V	30 <a href="#">See Schedule VIII</a>		<a href="#">King Management Company</a>	0.00%	6,860	6,860	12
13	V	34 <a href="#">See Schedule VIII</a>		<a href="#">King Management Company</a>	0.00%	5,359	5,359	13
14	Total		\$ 332,000			\$ 265,276	\$ * (66,724)	14

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

Facility Name & ID Number Aviston Countryside Manor, Inc. # 0033407 Report Period Beginning: 1/1/2018 Ending: 12/31/18

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Denise King	President	Administrative	20.00	186,638	9	23.00	Salary	\$ 80,387	17,8	1
2	Leslie Pedtke	Corp Educator	Administrative	20.00	175,730	9	23.00	Salary	75,689	17,8	2
3	Keith King		Administrative	20.00	953	1	23.00	Salary	410	17,8	3
4	Elizabeth King		Administrative	20.00	834	1	23.00	Salary	359	17,8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 156,845		13

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

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

Facility Name & ID Number Aviston Countryside Manor, Inc.

# 0033407

Report Period Beginning:

1/1/2018

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Accumulated Costs	15,673,161	6	\$ 18	\$ 3,670,669	\$ 4	1
2	5	Heat & Other Utilities	Accumulated Costs	15,673,161	6	3,457	3,670,669	810	2
3	6	Maintenance	Accumulated Costs	15,673,161	6	2,960	3,670,669	693	3
4	17	Administrative	Accumulated Costs	15,673,161	6	669,802	669,702	156,868	4
5	19	Professional Services	Accumulated Costs	15,673,161	6	17,295	3,670,669	4,051	5
6	20	Dues,Fees, Subscriptions, & Prom	Accumulated Costs	15,673,161	6	1,054	3,670,669	247	6
7	21	Clerical & General Office Expens	Accumulated Costs	15,673,161	6	314,561	277,254	73,670	7
8	22	Employee Benefits & Payroll Tax	Accumulated Costs	15,673,161	6	60,971	3,670,669	14,279	8
9	24	Travel & Seminar	Accumulated Costs	15,673,161	6	1,466	3,670,669	343	9
10	25	Other Admin Staff Transportatio	Accumulated Costs	15,673,161	6	5,353	3,670,669	1,254	10
11	26	Insurance-Prop,Liab,Malpractice	Accumulated Costs	15,673,161	6	3,577	3,670,669	838	11
12	30	Depreciation	Accumulated Costs	15,673,161	6	29,292	3,670,669	6,860	12
13	34	Rent-Facility & Grounds	Accumulated Costs	15,673,161	6	22,880	3,670,669	5,359	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,132,686	\$ 946,956	\$ 265,276	25

Facility Name & ID Number

Aviston Countryside Manor, Inc.

# 0033407

Report Period Beginning:

1/1/2018

Ending:

12/31/18

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

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

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

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

Facility Name & ID Number **Aviston Countryside Manor, Inc.**

# **0033407** Report Period Beginning:

**1/1/2018**

Ending:

**12/31/18**

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1.	Real Estate Tax accrual used on 2017 report.	\$	<b>38,000</b>		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.)	\$	<b>36,366</b>		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	<b>(1,634)</b>		3
4.	Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>37,100</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>35,466</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2013	<u>33,732</u>	8	
		2014	<u>33,689</u>	9	
		2015	<u>36,004</u>	10	
		2016	<u>36,593</u>	11	
		2017	<u>36,366</u>	12	
<b>Line 4: Accrual is based on 2017 taxes paid plus an inflationary increase.</b>					
				<b>FOR BHF USE ONLY</b>	
		13	FROM R. E. TAX STATEMENT FOR 2017	\$	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.**



**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 28,618 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Building &amp; Pkg Lot</u>	<u>108,900</u>	<u>1986</u>	<u>\$ 44,744</u>	1
2					2
3	<b>TOTALS</b>	<b>108,900</b>		<b>\$ 44,744</b>	3

Facility Name & ID Number Aviston Countryside Manor, Inc.# 0033407

Report Period Beginning:

1/1/2018 Ending: 12/31/18

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	70		1988	1988	\$ 1,472,741	\$ 8,008	30	\$ 8,182	\$ 174	\$ 1,472,741	4
5			1988	1988	66,310	368	30		(368)	66,310	5
6	27		1990	1990	352,911	13,097	30	11,764	(1,333)	336,245	6
7			1990	1990	6,649	227	30	221	(6)	6,344	7
8											8
	<b>Improvement Type**</b>										
9		Level & Remove Dirt		1988	1,428		10			1,428	9
10		Landscaping & Sod		1988	4,046		10			4,046	10
11		Shrubs		1988	1,219		10			1,219	11
12		Patio		1988	20,500		20			20,500	12
13		Parking Lot		1988	37,691		20			37,691	13
14		Landscaping & Sod		1988	1,900		10			1,900	14
15		Sidewalk & Patio		1988	1,161		20			1,161	15
16		Landscaping		1988	1,020		20			1,020	16
17		Door/Door Frames		1988	16,064		20			16,064	17
18		Finishing Work on Additions		1990	918		15			918	18
19		Storage Building		1993	3,900		15			3,900	19
20		Electrical Work		1994	2,293		10			2,293	20
21		Flooring		1995	9,255		10			9,255	21
22		Asphalt Parking Lot		1995	8,288		10			8,288	22
23		Double Detector Check Valve		1995	1,750		10			1,750	23
24		HVAC - Kitchen/Laundry		1996	14,577		17			14,577	24
25		Landscaping & Sod		1997	3,499		10			3,499	25
26		Vinyl Flooring		1997	2,570		10			2,570	26
27		Floor Tiles		1997	3,525		10			3,525	27
28		Water Heater		1999	3,468		15			3,468	28
29		Wallcovering/Flooring		1999	1,774		10			1,774	29
30		Carpet		1999	12,873		10			12,873	30
31		Window Treatments		1999	7,734		5			7,734	31
32		Renovation C-Wing		2000	6,749		15			6,749	32
33		Wallpaper		2000	7,178		5			7,178	33
34		Paint		2000	1,745		5			1,745	34
35		Dressers & Installation		2000	3,870		15			3,870	35
36		Countertops & Installation		2000	4,008	200	20	200		3,774	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Aviston Countryside Manor, Inc.# 0033407

Report Period Beginning:

1/1/2018

Ending:

12/31/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>Tile</u>	2000	\$ 1,857	\$	10	\$	\$	\$ 1,857	37
38	<u>Window Treatments</u>	2000	3,049		5			3,049	38
39	<u>Wanderguard System</u>	2000	2,102		10			2,102	39
40	<u>Room Doors</u>	2000	2,699		10			2,699	40
41	<u>Tile</u>	2000	2,515		10			2,515	41
42	<u>Gravel Parking Lot</u>	2000	2,698		5			2,698	42
43	<u>Air Conditioner Units (3)</u>	2000	1,770		5			1,770	43
44	<u>Tile</u>	2000	2,602		10			2,602	44
45	<u>Diamond Retaining Wall</u>	2001	1,980		10			1,980	45
46	<u>Cabinets</u>	2001	23,546		10			23,546	46
47	<u>Addition to Fire Alarm System</u>	2001	4,368		10			4,368	47
48	<u>Electrical Repairs to Service Entrance</u>	2001	6,725		10			6,725	48
49	<u>Carpet</u>	2001	3,051		10			3,051	49
50	<u>Door Security Systems</u>	2001	10,589		10			10,589	50
51	<u>Rooftop A/C Units (3)</u>	2002	14,243		10			14,243	51
52	<u>Dining Room Additions</u>	2003	8,600	215	40	215		3,333	52
53	<u>Parking Lot</u>	2003	5,446		10			5,446	53
54	<u>Landscaping</u>	2003	3,040		10			3,040	54
55	<u>Concrete Pad</u>	2004	4,000	267	15	267		3,822	55
56	<u>Landscaping</u>	2004	6,711		10			6,711	56
57	<u>Flooring</u>	2004	5,650		10			5,650	57
58	<u>Carpet</u>	2004	1,694		5			1,694	58
59	<u>Window Treatments</u>	2004	1,935		5			1,935	59
60	<u>Dining Room Additions</u>	2004	159,328	7,587	14	7,587		159,328	60
61	<u>Landscaping</u>	2004	8,297		10			8,297	61
62	<u>Floodlights</u>	2006	3,314		10			3,314	62
63	<u>Concrete Sidewalk</u>	2006	18,000	1,200	15	1,200		14,600	63
64	<u>Flooring</u>	2006	1,900		10			1,900	64
65	<u>Heat/Cool Unit</u>	2006	1,066		10			1,066	65
66	<u>Cast Iron Piping</u>	2006	11,825	473	25	473		5,952	66
67	<u>Sprinkler System</u>	2006	6,820		10			6,820	67
68	<u>Sprinkler System</u>	2007	41,900	1,676	25	1,676		19,553	68
69	<u>New Roofing</u>	2007	6,455		10			6,455	69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,463,389	\$ 33,318		\$ 31,785	\$ (1,533)	\$ 2,409,119	70

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

Facility Name & ID Number Aviston Countryside Manor, Inc.# 0033407

Report Period Beginning:

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12/31/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,463,389	\$ 33,318		\$ 31,785	\$ (1,533)	\$ 2,409,119	1
2	<u>Gazebo</u>	2007	5,659	377	15	377		4,370	2
3	<u>Paint</u>	2007	2,868		5			2,868	3
4	<u>Wall Covering Installation</u>	2007	5,600		5			5,600	4
5	<u>New Roofing</u>	2007	15,900		10			15,900	5
6	<u>Wall Guards</u>	2007	4,154	277	15	277		3,069	6
7	<u>Floor Covering</u>	2007	5,855		10			5,855	7
8	<u>Landscaping &amp; Electrical Work</u>	2008	3,284	137	10	137		3,284	8
9	<u>Landscaping</u>	2008	4,754	317	10	317		4,754	9
10	<u>Flooring</u>	2008	3,040	279	10	279		3,040	10
11	<u>Water Heater</u>	2009	6,108	611	10	611		5,701	11
12	<u>Water Softener System</u>	2009	11,812	1,181	10	1,181		11,517	12
13	<u>Oak Doors</u>	2009	2,274	152	15	152		1,402	13
14	<u>Carpet</u>	2009	1,200		5			1,200	14
15	<u>Sprinkler System Heads</u>	2010	3,210	128	25	128		1,081	15
16	<u>Shed</u>	2010	6,620	331	20	331		2,841	16
17	<u>Wallpaper</u>	2010	4,573		5			4,573	17
18	<u>Water Heater</u>	2010	6,108	611	10	611		4,988	18
19	<u>Ceiling Refinishes</u>	2011	3,450	288	12	288		2,108	19
20	<u>Nurse's Station</u>	2011	57,233	3,816	15	3,816		28,617	20
21	<u>Carpet</u>	2011	4,333		5			4,333	21
22	<u>Landscaping &amp; Stone Walk</u>	2011	9,511	951	10	951		7,054	22
23	<u>Facility Sign - Brick/Stucco</u>	2011	6,258	313	20	313		2,242	23
24	<u>Dining Room Chandeliers</u>	2011	2,876	288	10	288		2,253	24
25	<u>Paint</u>	2011	2,500		5			2,500	25
26	<u>Window Treatments &amp; Shutters</u>	2011	7,690	102	15	102		6,949	26
27	<u>Wallpaper</u>	2011	15,842		5			15,842	27
28	<u>Flooring</u>	2011	33,951	3,395	10	3,395		26,210	28
29	<u>Brickwork/Pattern Concrete with Ceramic Finish</u>	2012	31,667	1,583	20	1,583		10,819	29
30	<u>Aluminum Fence - 172 Feet</u>	2012	6,035	402	15	402		2,649	30
31	<u>Siding - Gable Ends</u>	2012	5,334	533	10	533		3,334	31
32	<u>Dry Pendant Sprinkler System Heads</u>	2012	3,193	160	20	160		985	32
33	<u>Natural Gas Generator &amp; Installation</u>	2012	25,730	1,287	20	1,287		8,469	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,772,011	\$ 50,837		\$ 49,304	\$ (1,533)	\$ 2,615,526	34

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

Facility Name & ID Number Aviston Countryside Manor, Inc.# 0033407

Report Period Beginning:

1/1/2018

Ending:

12/31/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,772,011	\$ 50,837		\$ 49,304	\$ (1,533)	\$ 2,615,526	1
2	<u>Wanderguard System</u>	2012	2,851	407	7	407		2,614	2
3	<u>Emergency Outlets &amp; Computer Outlets Installation</u>	2012	2,065	138	15	138		929	3
4	<u>Air Conditioner Unit - Laundry Room</u>	2012	2,403	240	10	240		1,562	4
5	<u>Shingle Roof</u>	2012	79,900	7,990	10	7,990		48,606	5
6	<u>Marble Showers (2)</u>	2012	14,730	737	20	737		4,419	6
7	<u>Tile Flooring</u>	2012	11,780	1,178	10	1,178		7,647	7
8	<u>Water Heaters (2)</u>	2012	14,917	1,492	10	1,492		9,010	8
9	<u>Protective Wall Coverings</u>	2013	3,432	343	10	343		2,031	9
10	<u>Beauty Shop &amp; Wall Finishes</u>	2013	5,550	463	12	463		2,621	10
11	<u>Plank Flooring</u>	2013	2,864	286	10	286		1,599	11
12	<u>Shower Doors</u>	2013	2,083	208	10	208		1,128	12
13	<u>Porcelain Shower Tile</u>	2013	2,198	110	20	110		614	13
14	<u>Attic Fireproofing</u>	2014	5,037	336	15	336		1,483	14
15	<u>5 Ton A/C Unit</u>	2014	5,250	525	10	525		2,494	15
16	<u>Heat Exchangers</u>	2015	6,600	440	15	440		1,650	16
17	<u>Compressor on A/C unit</u>	2015	2,000	133	15	133		444	17
18	<u>Gas Water Heater - 65 gal</u>	2015	7,122	712	10	712		2,314	18
19	<u>Plaster Ceilings in Office Area</u>	2016	1,922	128	15	128		352	19
20	<u>1600 Sq Ft Plank Flooring-C Hall rooms</u>	2016	6,793	679	10	679		1,868	20
21	<u>Replace driveway &amp; sidewalk</u>	2017	5,870	391	15	391		620	21
22	<u>Gas Water Heater, 100 Gallon</u>	2017	6,322	632	10	632		1,212	22
23	<u>13 Seer AC Unit</u>	2017	1,419	142	10	142		213	23
24	<u>Tempering Valve for Water Heater</u>	2018	4,500	450	10	450		450	24
25	<u>2 Glass Fire Doors</u>	2018	2,316	103	15	103		103	25
26	<u>Comfortmaker Rooftop AC/Heat unit, 7.5ton</u>	2018	10,250	598	10	598		598	26
27	<u>HVAC Economizer</u>	2018	1,395	58	10	58		58	27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,983,580	\$ 69,756		\$ 68,223	\$ (1,533)	\$ 2,712,165	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 217,898	\$ 21,160	\$ 23,647	\$ 2,487	3-15	\$ 126,322	71
72	Current Year Purchases	26,833	1,177	1,177		3-15	1,177	72
73	Fully Depreciated Assets	550,224	591	990	399	3-26	550,224	73
74								74
75	TOTALS	\$ 794,955	\$ 22,928	\$ 25,814	\$ 2,886		\$ 677,723	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2013 Ford E450 Bus	2016	\$ 39,004	\$ 9,751	\$ 9,751	\$	4	\$ 24,377	76
77	Home Office Auto	2017 Porsche Cayenne	2017	16,588		4,492	4,492	4	5,874	77
78	Facility	2017 Dodge Grand Caravan	2018	37,482	3,124	3,124		4	3,124	78
79										79
80	TOTALS			\$ 93,074	\$ 12,875	\$ 17,367	\$ 4,492		\$ 33,375	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,916,353	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,559	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 111,404	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,845	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,423,263	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	Outbuilding	\$ 17,573	\$	\$ 17,573	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 17,573	\$	\$ 17,573	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Section N/A

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

If NO, see instructions.

YES  NO

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

\*\*

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

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

9. Option to Buy:  YES  N/A NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  N/A NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2019 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2020 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2021 \$ \_\_\_\_\_

\* 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.

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)					
					Units	Cost						
1	Licensed Occupational Therapist		hrs	\$		\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs									4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39,2	# of prescripts					73,006			73,006	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Therapy</u>	39,3					355,791				355,791	12
13	Other (specify): <u>Labs,Xrays&amp;Supplies</u>	39,2 & 39,3					13,242	1,240			14,482	13
14	<b>TOTAL</b>			\$			\$ 369,033	\$ 74,246			\$ 443,279	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.

Facility Name & ID Number Aviston Countryside Manor, Inc.# 0033407Report Period Beginning: 1/1/2018

Ending:

12/31/18

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 874,391	\$	1
2	Cash-Patient Deposits	7,334		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>107,000</u> )	641,296		3
4	Supply Inventory (priced at <u>cost</u> )	5,964		4
5	Short-Term Investments			5
6	Prepaid Insurance	43,912		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,572,897	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,744		13
14	Buildings, at Historical Cost	3,001,972		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	827,972		16
17	Accumulated Depreciation (book methods)	(3,399,038)		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 (spec <u>Ppd 3rd Party Settler</u> )	150,177		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 625,827	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,198,724	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 233,713	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,834		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	152,900		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,460		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,100		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 450,007	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 450,007	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,748,717	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,198,724	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,608,140</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,608,140</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	665,577	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(525,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>140,577</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,748,717</b>	<b>24</b> *

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

## STATE OF ILLINOIS

Page 19

Facility Name & ID Number Aviston Countryside Manor, Inc.# 0033407Report Period Beginning: 1/1/2018Ending: 12/31/18**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,681,731	1
2	Discounts and Allowances for all Levels	(1,270,996)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,410,735	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,227,250	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,227,250	8
<b>C. Other Operating Revenue</b>			
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	8,839	19
20	Radiology and X-Ray	6,453	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 15,292	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	325	24
25	Interest and Other Investment Income***	5,429	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,754	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>	2,854	27
28	<b>Diapers/Depends</b>	5,889	28
28a	<b>Misc Other Revenue</b>	472	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,215	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,668,246	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	745,370	31
32	Health Care	1,600,929	32
33	General Administration	895,705	33
<b>B. Capital Expense</b>			
34	Ownership	141,025	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	443,573	35
36	Provider Participation Fee	176,067	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,002,669	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	665,577	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 665,577	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,439,755	44
45	Private Pay - Net Inpatient Revenue	1,618,905	45
46	Medicare - Net Inpatient Revenue	352,075	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,410,735	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

AVISTON COUNTRYSIDE MANOR, INC.  
Book to Tax Income Reconciliation  
ATTACHMENT TO SCHEDULE XVII  
12/31/2018

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 665,577
DEPRECIATION ADJUSTMENT	(32,251)
CONVERSION TO CASH BASIS ADJUSTMENTS	26,313
OTHER MISC BOOK TO TAX ADJUSTMENTS	8,660
TAX NET INCOME	<u>\$ 668,299</u>

AVISTON COUNTRYSIDE MANOR, INC.  
Detail of Other Revenue  
ATTACHMENT TO SCHEDULE XVII  
12/31/2018

Class action lawsuit settlement	294	offset to ln 39
Class action lawsuit settlement	2,560	offset to ln 7
Diapers/Depends	5,889	
Vending Machine commission	322	
Sales of memorial bricks/DVD's	80	offset to ln 11
Medical records copies	70	offset to ln 10
Other miscellaneous income	<u>9,215</u>	

Facility Name & ID Number Aviston Countryside Manor, Inc.# 0033407

Report Period Beginning:

1/1/2018

Ending:

12/31/18

## 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	1,962	2,027	\$ 62,737	\$ 30.95	1
2	Assistant Director of Nursing	1,054	1,216	30,000	24.67	2
3	Registered Nurses	9,686	10,011	254,807	25.45	3
4	Licensed Practical Nurses	10,189	10,815	233,065	21.55	4
5	CNAs & Orderlies	52,661	54,022	674,423	12.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,872	3,038	41,707	13.73	8
9	Activity Director	1,914	2,190	32,517	14.85	9
10	Activity Assistants	1,500	1,556	14,215	9.14	10
11	Social Service Workers	2,484	2,542	33,197	13.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,208	15,768	175,634	11.14	15
16	Dishwashers					16
17	Maintenance Workers	1,762	1,881	39,041	20.76	17
18	Housekeepers	11,009	11,421	114,299	10.01	18
19	Laundry	6,157	6,228	58,580	9.41	19
20	Administrator	2,009	2,120	83,535	39.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,875	1,950	32,416	16.62	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	1,607	1,715	21,354	12.45	31
32	Other Health Care: <u>MDS/CarePlan</u>	2,997	2,998	78,249	26.10	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,946	131,498	\$ 1,979,776 *	\$ 15.06	34

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

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	119	\$ 6,102	1,3	35
36	Medical Director	contract	2,400	9,3	36
37	Medical Records Consultant	16	960	10,3	37
38	Nurse Consultant	24	4,655	10,3	38
39	Pharmacist Consultant	contract	2,127	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	23	1,548	11,3	44
45	Social Service Consultant	23	1,548	12,3	45
46	Other(specify)				46
47	<u>Music Therapy</u>	48	3,240	11,3	47
48	<u>Art Therapy</u>	38	1,688	11,3	48
49	TOTAL (lines 35 - 48)	291	\$ 24,268		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	86	7,707	10,3	51
52	Certified Nurse Assistants/Aides	707	21,264	10,3	52
53	TOTAL (lines 50 - 52)	793	\$ 28,971		53



AVISTON COUNTRYSIDE MANOR, INC.  
 Legal Fees  
 ATTACHMENT TO SCHEDULE XIX-C  
 12/31/2018

<u>Invoice Date</u>	<u>Law Firm Name</u>	<u>Allowable/Non-allowable</u>	<u>Amount</u>	<u>Description</u>
1/31/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	120.00	Patient account collections
3/29/2018	Greensfelder, Hemker & Gale	allowable	152.00	question re: Protected health info
4/30/2018	Mathis, Marifian & Richter, Ltd	allowable	300.00	employee issue
4/30/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	560.00	Patient account collections
5/31/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	1,727.96	Patient account collections
4/30/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	(2,010.00)	recoupment of legal fees for collections
6/30/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	1,000.00	Patient account collections
7/31/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	2,225.00	Patient account collections
8/31/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	2,698.04	Patient account collections
9/30/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	4,572.80	Patient account collections
10/31/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	2,557.00	Patient account collections
11/30/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	80.00	Patient account collections
12/31/2018	Mathis, Marifian & Richter, Ltd	Non-allowable	250.29	Patient account collections
			<u>14,233.09</u>	
		Non-allowable	13,781.09	
		allowable	452.00	
			<u>14,233.09</u>	

Facility Name & ID Number Aviston Countryside Manor, Inc.# 0033407Report Period Beginning: 1/1/2018Ending: 12/31/18**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 \$4,144
- (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? 3-15 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,872 Line 10
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 176,067  
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.
- (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. \$ N/A
- (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 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. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.