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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0053264

Facility Name: Pontiac Healthcare and Rehab

Address: 300 West Lowell (Number) Pontiac (City) 61764 (Zip Code)

County: Livingston

Telephone Number: (815) 842-1181 **Fax #** (815) 842-3406

HFS ID Number:

Date of Initial License for Current Owners: 10/15/14

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		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
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 1/1/16 to 12/31/16 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)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	37	Skilled (SNF)	37	13,542	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,960	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,502	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,471	746	4,546	11,763	8
9	SNF/PED					9
10	ICF	10,674	3,243		13,917	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,145	3,989	4,546	25,680	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.33%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold 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] Non-allowable costs have been eliminated in Schedule V, Column 7

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 10/15/14

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/15/14 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 37 and days of care provided 3,699

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: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	182,536	12,999	7,080	202,615		202,615		202,615			1
2	Food Purchase		118,468		118,468		118,468		118,468			2
3	Housekeeping	144,784	15,615		160,399		160,399		160,399			3
4	Laundry	33,831	14,603		48,434		48,434		48,434			4
5	Heat and Other Utilities			109,361	109,361		109,361	545	109,906			5
6	Maintenance	37,501	25,779	34,994	98,274		98,274	145	98,419			6
7	Other (specify):* Waste Removal			14,543	14,543		14,543		14,543			7
8	TOTAL General Services	398,652	187,464	165,978	752,094		752,094	690	752,784			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,538,507	113,904	7,834	1,660,245		1,660,245	61,889	1,722,134			10
10a	Therapy	21,345		350	21,695		21,695		21,695			10a
11	Activities	140,237		4,730	144,967		144,967		144,967			11
12	Social Services	53,220		2,921	56,141		56,141		56,141			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. Emp Benefits							10,569	10,569			15
16	TOTAL Health Care and Programs	1,753,309	113,904	23,035	1,890,248		1,890,248	72,458	1,962,706			16
	C. General Administration											
17	Administrative	100,828		252,755	353,583		353,583	(208,580)	145,003			17
18	Directors Fees											18
19	Professional Services			59,482	59,482		59,482	2,515	61,997			19
20	Dues, Fees, Subscriptions & Promotions			12,986	12,986		12,986	(1,427)	11,559			20
21	Clerical & General Office Expenses	82,938	5,581	59,883	148,402		148,402	95,622	244,024			21
22	Employee Benefits & Payroll Taxes			364,080	364,080		364,080		364,080			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,773	3,773		3,773	6,238	10,011			24
25	Other Admin. Staff Transportation			15,612	15,612		15,612	3,059	18,671			25
26	Insurance-Prop.Liab.Malpractice			79,555	79,555		79,555	599	80,154			26
27	Other (specify):* Alloc. Emp Benefits							21,424	21,424			27
28	TOTAL General Administration	183,766	5,581	848,126	1,037,473		1,037,473	(80,550)	956,923			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,335,727	306,949	1,037,139	3,679,815		3,679,815	(7,402)	3,672,413			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 Pontiac Healthcare and Rehab #0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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			24,000	24,000		24,000	(13,795)	10,205			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,134	58,134		58,134	(52)	58,082			32
33	Real Estate Taxes			64,575	64,575		64,575		64,575			33
34	Rent-Facility & Grounds			551,728	551,728		551,728	4,662	556,390			34
35	Rent-Equipment & Vehicles			22,705	22,705		22,705	(851)	21,854			35
36	Other (specify):*											36
37	TOTAL Ownership			721,142	721,142		721,142	(10,036)	711,106			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		112,026	560,432	672,458		672,458		672,458			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			189,000	189,000		189,000		189,000			42
43	Other (specify):* See Att Sch 4A	61,821		82,494	144,315		144,315	(128,463)	15,852			43
44	TOTAL Special Cost Centers	61,821	112,026	831,926	1,005,773		1,005,773	(128,463)	877,310			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,397,548	418,975	2,590,207	5,406,730		5,406,730	(145,901)	5,260,829			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

Pontiac Healthcare and Rehab

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			13,195	13,195		13,195		13,195			
	Radiology Expenses			2,657	2,657		2,657		2,657			
	Non-Allowable Expenses	61,821		66,642	128,463		128,463	(128,463)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	61,821	0	82,494	144,315	0	144,315	(128,463)	15,852			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	(21,452)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,795)	30		9
10	Interest and Other Investment Income	(52)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(52)	43		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	(500)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(60)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,945)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,000)	43		24
25	Fund Raising, Advertising and Promotional	(15,078)	43		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 See Page 5A	(70,042)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (152,976)		$	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)	7,075		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 7,075		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (145,901)		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

Pontiac Healthcare and Rehab

ID# 0053264

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Wages	(37,491)	43	1
2	Marketing Liason	(24,330)	43	2
3	Marketer Car Lease	(4,946)	35	3
4	Offset Miscellaneous Income Against Expense	(1,298)	21	4
5	Disallow PAC Dues	(1,977)	20	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
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(70,042)		49

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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

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

1	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	Certified Health Management, Inc.	100.00%	$ 545	$ 545	1
2	V	6	Maintenance		Certified Health Management, Inc.	100.00%	145	145	2
3	V	10	Nursing and Medical Records		Certified Health Management, Inc.	100.00%	61,889	61,889	3
4	V	15	Emp Benefit Alloc-Healthcare		Certified Health Management, Inc.	100.00%	10,569	10,569	4
5	V	17	Administrative	252,755	Certified Health Management, Inc.	100.00%	44,175	(208,580)	5
6	V	19	Professional Services		Certified Health Management, Inc.	100.00%	4,460	4,460	6
7	V	20	Dues, Fees, Subs & Promo		Certified Health Management, Inc.	100.00%	1,050	1,050	7
8	V	21	Clerical & Gen Office Expenses		Certified Health Management, Inc.	100.00%	96,920	96,920	8
9	V	24	Travel and Seminar		Certified Health Management, Inc.	100.00%	6,238	6,238	9
10	V	25	Other Admin Staff Transportation		Certified Health Management, Inc.	100.00%	3,059	3,059	10
11	V	26	Ins.-Prop, Liab, Malpractice		Certified Health Management, Inc.	100.00%	599	599	11
12	V	27	Emp Benefit Alloc-Gen Admin		Certified Health Management, Inc.	100.00%	21,424	21,424	12
13	V	34	Rent-Facility & Grounds		Certified Health Management, Inc.	100.00%	4,662	4,662	13
14	Total			$ 252,755			$ 255,735	$ * 2,980	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Rent-Equipment & Vehicle	$	Certified Health Management, Inc.	100.00%	$ 4,095	$ 4,095	15
16	V								16
17	V								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			$			$ 4,095	$ * 4,095	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Atied Associates	40	Glenwood Healthcare & Rehab	Glenwood	Certified Health	Skokie	Management	1
2	Bradley M. Alter	60	Prairie View Care Center of Lewistown	Lewistown	Management, Inc.			2
3			Renaissance Care Center	Canton				3
4			Paxton Healthcare and Rehab	Paxton				4
5			Danville Care Center	Danville				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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	Daniel Alter	Relative	Financial	0.00	See Att Sch 7A	5.18	12.95	Alloc. Salary	$ 6,558	L21, C7	1
2	Zev Geller	Relative	Clerical	0.00	See Att Sch 7A	5.18	12.95	Alloc. Salary	8,656	L21, C7	2
3	Bradley Alter	Owner	Administration	60.00	See Att Sch 7A	6.48	12.96	Alloc. Salary	23,958	L17, C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 39,172		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 Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 [ ]

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

Name of Related Organization: Certified Health Management, Inc.
Street Address: 3856 W. Oakton
City / State / Zip Code: Skokie, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	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 and Other Utilities	Census Days	198,295	6	$ 4,208	$	25,680	$ 545	1
2	6	Maintenance	Census Days	198,295	6	1,116		25,680	145	2
3	10	Nursing and Medical Records	Census Days	198,295	6	477,896	477,896	25,680	61,889	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	198,295	6	81,613		25,680	10,569	4
5	17	Administrative	Census Days	198,295	6	341,110	341,110	25,680	44,175	5
6	19	Professional Services	Census Days	198,295	6	34,439		25,680	4,460	6
7	20	Dues, Fees, Subs & Promo	Census Days	198,295	6	8,110		25,680	1,050	7
8	21	Clerical & Gen Office Expenses	Census Days	198,295	6	748,394	627,598	25,680	96,920	8
9	24	Travel and Seminar	Census Days	198,295	6	48,168		25,680	6,238	9
10	25	Other Admin Staff Transportatior	Census Days	198,295	6	23,623		25,680	3,059	10
11	26	Ins.-Prop, Liab, Malpractice	Census Days	198,295	6	4,628		25,680	599	11
12	27	Emp Benefit Alloc-Gen Admin	Census Days	198,295	6	165,432		25,680	21,424	12
13	34	Rent-Facility & Grounds	Census Days	198,295	6	36,000		25,680	4,662	13
14	35	Rent-Equipment & Vehicle	Census Days	198,295	6	31,619		25,680	4,095	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,006,356	$ 1,446,604		$ 259,830	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Bank Leumi		X	Line of Credit				1,384,134			56,960	6
7	Insurance Financing		X								1,174	7
8												8
9	TOTAL Facility Related						$	$ 1,384,134			$ 58,134	9
	B. Non-Facility Related*											
10												10
11												11
12								Offset Interest Income			(52)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (52)	14
15	TOTALS (line 9+line14)						$	$ 1,384,134			$ 58,082	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 Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 65,169	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.)	2015	$ 61,801	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,368)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 67,943	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.		$ 64,575	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	46,309	8
	2012	62,385	9
	2013	62,967	10
	2014	63,271	11
	2015	61,801	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pontiac Healthcare and Rehab COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0053264

CONTACT PERSON REGARDING THIS REPORT Bruce Harris

TELEPHONE (847) 674-4700 FAX #: (847) 674-4733

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-15-27-255-014	Long Term Care Property	$ 61,801.40	$ 61,801.40
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,801.40	$ 61,801.40

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 a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,600 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Installation Of Camera Monitor System			2015	18,200		20	910	910	1,098	9
10	Phone System			2015	5,025		20	251	251	1,005	10
11	Boiler Repair			2015	3,942		20	197	197	246	11
12	Boiler Repair			2015	11,828		20	591	591	739	12
13	Generator Repair			2015	2,639		20	132	132	154	13
14	Roof Repairs Along Gutter Line			2015	4,250		20	213	213	426	14
15	Generator Repair			2016	7,233		20	362	362	362	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23	Financial Statement Depreciation					24,000			(24,000)		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 Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Allocated from Certified Health Management	1997	12,202		20			12,202	43
44	Allocated from Certified Health Management	2014	3,431		20	172	172	600	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)		$ 68,750	$ 24,000		$ 2,828	$ (21,172)	$ 16,832	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 67,442	$	$ 6,744	$ 6,744	10	$ 13,488	71
72	Current Year Purchases	6,333		633	633	10	633	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 73,775	$	$ 7,377	$ 7,377		$ 14,121	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				$	$	$	$		$	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)	$ 142,525	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 24,000	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 10,205	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,795)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 30,953	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		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Pontiac Health Care Property LLC

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:	1962	97	10/15/14	$ 551,728	10		3
4	Additions							4
5	Allocated from Management Co.				4,662			5
6								6
7	TOTAL		97		$ 556,390 **			7

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

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

10. Effective dates of current rental agreement:
Beginning 10/15/14
Ending 10/31/24

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

	Fiscal Year Ending	Annual Rent
12.	10/31/17	$ 566,484
13.	10/31/18	$ 584,184
14.	10/31/19	$ 601,884

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 6,971 Description: Copier (6,469), Dishwasher (502)
(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	Facility	2015 Ford Challenger	$ 899.00	$ 10,788	17
18					18
19	Allocated from Management Co.			4,095	19
20					20
21	TOTAL		$ 899.00	$ 14,883	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 Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$		$ 247,396	$		$ 247,396	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			49,013			49,013	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			264,023			264,023	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				112,026		112,026	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 560,432	$ 112,026		$ 672,458	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 Pontiac Healthcare and Rehab **#** 0053264 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ (152,262)	$ (152,262)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	2,117,296	2,117,296	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,232	55,232	6
7	Other Prepaid Expenses	29,024	29,024	7
8	Accounts Receivable (owners or related parties)	328,711	328,711	8
9	Other(specify): See Attached Schedule 17A	63,731	63,731	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,441,732	$ 2,441,732	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	32,022	68,750	15
16	Equipment, at Historical Cost	96,130	73,775	16
17	Accumulated Depreciation (book methods)	(39,171)	(30,953)	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 (spe LTC Mgmt Stock	23,000	23,000	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 111,981	$ 134,572	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,553,713	$ 2,576,304	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 453,180	$ 453,180	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,384,134	1,384,134	29
30	Accrued Salaries Payable	157,458	157,458	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,296	16,296	31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,943	67,943	32
33	Accrued Interest Payable	8,053	8,053	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,087,064	$ 2,087,064	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 Shareholders	200,000	200,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 200,000	$ 200,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,287,064	$ 2,287,064	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 266,649	$ 289,240	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,553,713	$ 2,576,304	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Pontiac Healthcare and Rehab**
IDPH License ID Number: **0053264**
Fiscal Year End: **12/31/16**

Schedule 17A

XV. Balance Sheet
Line 9 Other Current Assets (specify):

Description	Operating	After Consolidation
Due from Prior Owner	1,253	1,253
RE Escrow Deposit	62,478	62,478
Total - Line 9	**63,731**	**63,731**

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 500,679	1
2	Restatements (describe): Bad Debt Expense		2
3	See Attached Schedule 18A	(220,381)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 280,298	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(13,649)	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)**	$ (13,649)	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)**	$ 266,649	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Pontiac Healthcare and Rehab**
IDPH License ID Number: **0053264**
Fiscal Year End: **12/31/16**

Schedule 18A

XVI. Statement of Changes in Equity
Line 2 Restatements

Description	Amount
Audit-Rate Adjustment	(78,088)
Bad Debt Expense	(142,035)
Miscellaneous Difference	(258)
Total	**(220,381)**

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,164,351	1
2	Discounts and Allowances for all Levels	(19,594)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,144,757	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	246,692	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 246,692	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	282	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 282	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	52	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 52	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,298	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,298	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,393,081	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	752,094	31
32	Health Care	1,890,248	32
33	General Administration	1,037,473	33
	B. Capital Expense		
34	Ownership	721,142	34
	C. Ancillary Expense		
35	Special Cost Centers	816,773	35
36	Provider Participation Fee	189,000	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,406,730	40
41	**Income before Income Taxes (line 30 minus line 40)****	(13,649)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (13,649)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,406,590	44
45	Private Pay - Net Inpatient Revenue	800,709	45
46	Medicare - Net Inpatient Revenue	1,627,196	46
47	Other-(specify) Managed Care	215,356	47
48	Other-(specify) Hospice	94,906	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,144,757	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **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 Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,072	2,303	$ 89,268	$ 38.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,874	9,286	257,973	27.78	3
4	Licensed Practical Nurses	14,985	16,422	386,908	23.56	4
5	CNAs & Orderlies	55,009	58,253	714,533	12.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,410	1,526	21,345	13.99	8
9	Activity Director	1,792	1,832	42,154	23.01	9
10	Activity Assistants	9,973	10,765	98,083	9.11	10
11	Social Service Workers	2,000	2,120	32,430	15.30	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,186	43,280	19.80	13
14	Head Cook	7,483	8,414	80,805	9.60	14
15	Cook Helpers/Assistants	6,714	6,791	58,451	8.61	15
16	Dishwashers					16
17	Maintenance Workers	1,949	1,949	37,501	19.24	17
18	Housekeepers	13,437	14,530	144,784	9.96	18
19	Laundry	3,398	3,826	33,831	8.84	19
20	Administrator	2,000	2,226	100,828	45.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,182	5,735	82,938	14.46	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					31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	8,189	8,704	172,436	19.81	33
34	TOTAL (lines 1 - 33)	146,443	156,868	$ 2,397,548 *	$ 15.28	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	50	$ 7,080	L1,C3	35
36	Medical Director	Monthly	7,200	L9,C3	36
37	Medical Records Consultant	49	2,464	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	107	5,370	L10,C3	39
40	Physical Therapy Consultant	7	350	L10A,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	58	2,921	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	271	$ 25,385		49

C. CONTRACT NURSES

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

Pontiac Healthcare and Rehab

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		2,497	2,703	89,825	33.23
Transportation		1,789	1,789	20,790	11.62
Marketing		3,903	4,212	61,821	14.68
	TOTAL	8,189	8,704	172,436	

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carolyn McBride	Administrator	0	$ 55,750
Penny Varnavas	Administrator	0	45,078
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,828

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 252,755
TOTAL (agree to Schedule V, line 17, col. 3)	$ 252,755
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Service	$ 5,110
E-Health Data Solutions	Data Processing	900
PayChex	Payroll Service	20,214
MPRO	Peer Review Consulting	1,310
Ability Network	Data Processing	3,744
On Shift	Data Processing	1,481
Personnel Planners	Unemployment Consulting	630
Wescom Solutions Inc	Data Processing	21,871
See Attached Legal Schedule	Legal Fees	4,222
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 59,482

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,576
Unemployment Compensation Insurance	30,943
FICA Taxes	181,171
Employee Health Insurance	65,812
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	1,910
Pension Plan Contribution	10,668
TOTAL (agree to Schedule V, line 22, col.8)	$ 364,080

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,221
Health Care Worker Background Check	
(Indicate # of checks performed 181)	1,810
Patient Background Checks	
IL Council on LTC	5,930
Dues & Subscriptions	120
Licenses & Permits	415
Allocated from Management Co.	1,050
Less PAC Dues	(1,977)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,559

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,773
Allocated from Management Co.	6,238
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,011

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pontiac Healthcare and Rehab # 0053264 Report Period Beginning: 1/1/16 Ending: 12/31/16

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? **None**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,269** 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. $ **189,000**
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? **Yes**

(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? **N/A** 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? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
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