FOR BHF USE

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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: 0054791

Facility Name: Accolade Healthcare of Paxton Senior Living

Address: 450 E Fulton St (Number) Paxton (City) 60957 (Zip Code)

County: Ford

Telephone Number: (212) 379-2116 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2017

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Sam Freedman **Telephone Number:** (973) 557-3339
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 01/01/2018 to 12/31/2018 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) Moshe Freedman
(Title) President

Paid Preparer

(Signed) See Attached Report (Date)
(Print Name and Title) Deandra Fallon, Senior Manager
(Firm Name & Address) Baker Tilly Virchow Krause, LLP, 46 Public Square, Suite 400, Wilkes-Barre, PA 18701
(Telephone) (570) 820-0100 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 CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	75	Skilled (SNF)	75	27,375	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	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	8,863	5,850	3,380	18,093	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,863	5,850	3,380	18,093	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.09%

D. How many bed reserve days during this year were paid by the Department?
0 (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)
Meals on wheels

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/01/2017

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/2017 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 75 and days of care provided 2,409

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: _____ Fiscal Year: _____

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

SEE CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		9,925	395,417	405,342		405,342	(52,200)	353,142			1
2	Food Purchase		218		218		218		218			2
3	Housekeeping	80,265	23,342		103,607		103,607	(15,932)	87,675			3
4	Laundry	22,144	15,328		37,472		37,472		37,472			4
5	Heat and Other Utilities			103,252	103,252		103,252	(15,877)	87,375			5
6	Maintenance	87,440	25,945	29,038	142,423		142,423	(26,206)	116,217			6
7	Other (specify):* See attached			41,812	41,812		41,812	(6,429)	35,383			7
8	**TOTAL General Services**	189,849	74,758	569,519	834,126		834,126	(116,644)	717,482			8
	B. Health Care and Programs											
9	Medical Director			17,400	17,400		17,400		17,400			9
10	Nursing and Medical Records	1,117,490	97,502	55,032	1,270,024		1,270,024	2,910	1,272,934			10
10a	Therapy			2,306	2,306		2,306		2,306			10a
11	Activities	72,169	6,409	1,662	80,240		80,240		80,240			11
12	Social Services	44,441		972	45,413		45,413		45,413			12
13	CNA Training											13
14	Program Transportation	36,476		6,167	42,643		42,643		42,643			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,270,576	103,911	83,539	1,458,026		1,458,026	2,910	1,460,936			16
	C. General Administration											
17	Administrative	87,218		17,102	104,320		104,320		104,320			17
18	Directors Fees											18
19	Professional Services			342,545	342,545		342,545	(48,432)	294,113			19
20	Dues, Fees, Subscriptions & Promotions			7,988	7,988		7,988	(3,839)	4,149			20
21	Clerical & General Office Expenses	166,997	12,926	86,718	266,641		266,641	(38,156)	228,485			21
22	Employee Benefits & Payroll Taxes			367,491	367,491		367,491	(5,357)	362,134			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,077	12,077		12,077	(12,077)				24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			64,227	64,227		64,227		64,227			26
27	Other (specify):*											27
28	**TOTAL General Administration**	254,215	12,926	898,148	1,165,289		1,165,289	(107,861)	1,057,428			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,714,640	191,595	1,551,206	3,457,441		3,457,441	(221,595)	3,235,846			29

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

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

Accolade Healthcare of Paxton Senior Living
Line 7 Support
12/31/2018

	Salary/Wage 1	Supplies 2	Other 3	Total 4
Fire & Safety Services	-	-	15,459	15,459
Waste Removal	-	-	6,618	6,618
Landscaping	-	-	17,455	17,455
Exterminator	-	-	2,280	2,280
Total, Line 7	-	-	41,812	41,812

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living #0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			6,397	6,397		6,397	(649)	5,748			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,774	15,774		15,774	(31)	15,743			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			244,216	244,216		244,216	(37,553)	206,663			34
35	Rent-Equipment & Vehicles			3,607	3,607		3,607	(3,607)				35
36	Other (specify):*											36
37	**TOTAL Ownership**			269,994	269,994		269,994	(41,840)	228,154			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			548	548		548		548			38
39	Ancillary Service Centers		77,349	523,988	601,337		601,337		601,337			39
40	Barber and Beauty Shops			7,047	7,047		7,047		7,047			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,489	131,489		131,489		131,489			42
43	Other (specify):* See attached			114,979	114,979		114,979	(96,489)	18,490			43
44	**TOTAL Special Cost Centers**		77,349	778,051	855,400		855,400	(96,489)	758,911			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,714,640	268,944	2,599,251	4,582,835		4,582,835	(359,924)	4,222,911			45

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

SEE CONSULTANTS' REPORT

Accolade Healthcare of Paxton Senior Living
Line 43 Support
12/31/2018

	Salary/Wage 1	Supplies 2	Other 3	Total 4
Laboratory	-	-	6,895	6,895
Radiology	-	-	11,595	11,595
Meals on Wheels	-	-	1,512	1,512
Employee personal expenses	-	-	120	120
Advertising & Marketing	-	-	27,992	27,992
Charitable contributions	-	-	3,977	3,977
Start up expenses	-	-	(146)	(146)
Penalty and late fees	-	-	535	535
Theft and loss	-	-	376	376
Bad debt expense	-	-	62,123	62,123
Total, Line 43	-	-	114,979	114,979

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(172)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	215	30		9
10	Interest and Other Investment Income	(31)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(12,077)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(535)	43		18
19	Entertainment				19
20	Contributions	(3,977)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(47,841)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(62,123)	43		24
25	Fund Raising, Advertising and Promotional	(27,992)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(743)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (155,276)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (155,276)		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE CONSULTANTS' REPORT

STATE OF ILLINOIS

Accolade Healthcare of Paxton Senior Living

ID# 0054791

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Start Up Expenses	$ 146	43	1
2	Theft and Loss	(376)	43	2
3	Painting - Included in ownership costs	(4,306)	6	3
4	Equipment below $2,500 capitalization threshold	2,910	10	4
5	Equipment below $2,500 capitalization threshold	1,656	1	5
6	Equipment below $2,500 capitalization threshold	2,674	21	6
7	Depreciation for items below capitalization threshold	(864)	30	7
8	ILU Dietary Costs	(53,856)	1	8
9	ILU Housekeeping Costs	(15,932)	3	9
10	ILU Utilities Costs	(15,877)	5	10
11	ILU Maintenance Costs	(21,900)	6	11
12	ILU Other General Services	(6,429)	7	12
13	ILU Rent	(37,553)	34	13
14	Non-Allowable Dues and Subscriptions	(3,096)	20	14
15	Non-Allowable Bank Charges	(3,370)	21	15
16	Auto Lease - Non-Allowable	(3,607)	35	16
17	Marketing Salaries	(24,192)	21	17
18	Marketing Benefits	(5,185)	22	18
19	Meals on wheels	(1,512)	43	19
20	Personal expenses	(120)	43	20
21	Adjust finance salaries based on total allocated cost	(13,268)	21	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(204,057)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(52,200)	0	0	0	0	0	0	0	0	0	0	(52,200)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(15,932)	0	0	0	0	0	0	0	0	0	0	(15,932)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(15,877)	0	0	0	0	0	0	0	0	0	0	(15,877)	5
6	Maintenance	(26,206)	0	0	0	0	0	0	0	0	0	0	(26,206)	6
7	Other (specify):*	(6,429)	0	0	0	0	0	0	0	0	0	0	(6,429)	7
8	**TOTAL General Services**	(116,644)	0	0	0	0	0	0	0	0	0	0	(116,644)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	2,910	0	0	0	0	0	0	0	0	0	0	2,910	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	**TOTAL Health Care and Programs**	2,910	0	0	0	0	0	0	0	0	0	0	2,910	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(47,841)	(591)	0	0	0	0	0	0	0	0	0	(48,432)	19
20	Fees, Subscriptions & Promotions	(3,839)	0	0	0	0	0	0	0	0	0	0	(3,839)	20
21	Clerical & General Office Expenses	(38,156)	0	0	0	0	0	0	0	0	0	0	(38,156)	21
22	Employee Benefits & Payroll Taxes	(5,357)	0	0	0	0	0	0	0	0	0	0	(5,357)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(12,077)	0	0	0	0	0	0	0	0	0	0	(12,077)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(107,270)	(591)	0	0	0	0	0	0	0	0	0	(107,861)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(221,004)	(591)	0	0	0	0	0	0	0	0	0	(221,595)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 **Report Period Beginning:** 01/01/2018 **Ending:** 12/31/2018

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(649)	0	0	0	0	0	0	0	0	0	0	(649)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31)	0	0	0	0	0	0	0	0	0	0	(31)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(37,553)	0	0	0	0	0	0	0	0	0	0	(37,553)	34
35	Rent-Equipment & Vehicles	(3,607)	0	0	0	0	0	0	0	0	0	0	(3,607)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(41,840)	0	0	0	0	0	0	0	0	0	0	(41,840)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(96,489)	0	0	0	0	0	0	0	0	0	0	(96,489)	43
44	**TOTAL Special Cost Centers**	(96,489)	0	0	0	0	0	0	0	0	0	0	(96,489)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(359,333)	(591)	0	0	0	0	0	0	0	0	0	(359,924)	45

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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
Moshe Freedman	99%	Accolade Healthcare of Pontiac	Pontiac	Accolade Healthcare, I	Chicago	Management Compa
Elizabeth Deutsch Freedman	1%	Accolade HC of Paxton on Pells	Paxton			
		Accolade Healthcare of Paxton	Paxton			

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	19	Management Fees	$ 140,000	Accolade Healthcare, LLC	100.00%	$ 139,409	$ (591)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 140,000			$ 139,409	$ * (591)	14

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

SEE CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	Moshe Freedman	Owner	Administration	99.00	See attached 7A	11	28.68	Alloc Salary	$ 48,755	L19, C3	1
2	Shmuel Freedman	Relative	Finance	0.00	See attached 7A	11	28.68	Alloc Salary	19,252	L21, C1	2
3	Shmuel Freedman	Relative	Finance		See attached 7A	11	28.68	Alloc Salary	8,979	L19, C3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 76,986		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 Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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: Accolade Healthcare
Street Address:
City / State / Zip Code:
Phone Number: ( )
Fax Number: ( )

	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	19	Management Fees	Direct Cost	15,466,111	4	$ 486,000	$ 147,802	4,436,440	$ 139,409	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 486,000	$ 147,802		$ 139,409	25

SEE CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	See Attachment 9A						$ 200,000	$ 200,000			$ 12,000	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Miscellaneous Interest										3,774	6
7												7
8												8
9	TOTAL Facility Related						$ 200,000	$ 200,000			$ 15,774	9
	B. Non-Facility Related*											
10												10
11	Interest Income Offset										(31)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (31)	14
15	TOTALS (line 9+line14)						$ 200,000	$ 200,000			$ 15,743	15

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

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

SEE CONSULTANTS' 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 Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2013	8
	2014	9
	2015	10
	2016	11
	2017	12

FOR BHF USE ONLY

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.

Accolade Healthcare of Paxton Senior Living
Real Estate Taxes
12/31/2018

Accolade Healthcare of Paxton Senior Living is a corporation. However, it was previously a not-for-profit facility. Real estate taxes have not been assessed on the facility as of the current date and management has not been able to estimate what the real estate taxes will be. Therefore, there are no real estate taxes included in the cost report.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Accolade Healthcare of Paxton Senior Living COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0054791

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (___) _____ FAX #: (___) _____

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,268 B. General Construction Type: Exterior Brick Frame Fire Resistant Number of Stories 2

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).

Accolade Healthcare of Paxton Senior Living - Townhouse Apartments : 2,862 Sq Ft; 4 units

Accolade Healthcare of Paxton Senior Living - Independent Living Units (ILUs): 3,330 Sq Ft; 11 units

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 CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	HVAC system replacement			2018	13,587	557	10	557		557	9
10	Dishwasher Pump			2018	2,658	66	10	66		66	10
11	Painting - Reclass from R&M			2018	4,306		10	215	215	215	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 20,551	$ 623		$ 838	$ 215	$ 838	70

SEE CONSULTANTS' REPORT

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

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 18,395	$ 3,679	$ 3,679	$	5	$ 4,236	71
72	Current Year Purchases	14,474	1,231	1,231		5	1,231	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 32,869	$ 4,910	$ 4,910	$		$ 5,467	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)	$ 53,420	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 5,533	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 5,748	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 215	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,305	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					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

SEE CONSULTANTS' REPORT

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

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Fulton Street 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. [ ] YES [X] 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	75	10/1/2017	$ 241,096	3	3	3
4	Additions							4
5								5
6								6
7	TOTAL		75		$ 241,096 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 3,120
   This amount was calculated by dividing the total amount to be amortized 1,215,220
   by the length of the lease 36 mos .

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

10. Effective dates of current rental agreement:
    Beginning 10/17/18
    Ending 10/30/21

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2019	$ 391,625
13.	12/31/2020	$ 401,416
14.	12/31/2021	$ 341,453

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living

STATE OF ILLINOIS
0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	3,365	$ 231,922	$	3,365	$ 231,922	1
2	Licensed Speech and Language Development Therapist		hrs		459	37,901		459	37,901	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		3,605	254,125		3,605	254,125	4
5	Physician Care		visits							5
6	Dental Care		visits			40			40	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				77,349		77,349	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			$	7,429	$ 523,988	$ 77,349	7,429	$ 601,337	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 CONSULTANTS' REPORT

STATE OF ILLINOIS

Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ (13,177)	$ (13,177)	1
2	Cash-Patient Deposits	13,100	13,100	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 62,000)	950,652	950,652	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,049	9,049	6
7	Other Prepaid Expenses	3,174	3,174	7
8	Accounts Receivable (owners or related parties)	123,623	123,623	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,086,421	$ 1,086,421	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	17,882	17,882	15
16	Equipment, at Historical Cost	40,110	40,110	16
17	Accumulated Depreciation (book methods)	(6,967)	(6,967)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attached schedule	10,343	10,343	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 61,368	$ 61,368	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,147,789	$ 1,147,789	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 873,752	$ 873,752	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,100	13,100	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,382	43,382	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached schedule	21,052	21,052	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 951,286	$ 951,286	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	200,000	200,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attached schedule	25,787	25,787	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 225,787	$ 225,787	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,177,073	$ 1,177,073	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (29,284)	$ (29,284)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,147,789	$ 1,147,789	48

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***(See instructions.)**

Accolade Healthcare of Paxton Senior Living
Page 17 Detail
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	Operating 1	After Consolidation 2
Line 23:		
MCO Contract Costs	1,800	1,800
Accumulated Amortization of MCO Contracts	(1,200)	(1,200)
Cap Ex Reserve	9,743	9,743
Total, Line 23	10,343	10,343
Line 36:		
Accrued Bed Tax	(9,955)	(9,955)
Accrued Management Fees	(1,798)	(1,798)
Accrued Payroll Taxes	(9,299)	(9,299)
Total, Line 36	(21,052)	(21,052)
Line 43:		
Due to Old Owner	(12,177)	(12,177)
Payroll Company	2,663	2,663
Deferred Rent Liability	(3,120)	(3,120)
Unearned Revenue	(13,153)	(13,153)
Total, Line 43	(25,787)	(25,787)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (40,915)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (40,915)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	11,631	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)**	$ 11,631	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)**	$ (29,284)	24 *

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

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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	$ 5,446,407	1
2	Discounts and Allowances for all Levels	(1,190,856)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,255,551	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	304,009	6
7	Oxygen	3,417	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 307,426	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	11,506	13
14	Non-Patient Meals	172	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 11,678	23
	D. Non-Operating Revenue		
24	Contributions	14,295	24
25	Interest and Other Investment Income***	31	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,326	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	5,485	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,485	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,594,466	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	834,126	31
32	Health Care	1,458,026	32
33	General Administration	1,165,289	33
	B. Capital Expense		
34	Ownership	269,994	34
	C. Ancillary Expense		
35	Special Cost Centers	723,911	35
36	Provider Participation Fee	131,489	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,582,835	40
41	**Income before Income Taxes (line 30 minus line 40)****	11,631	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 11,631	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,343,396	44
45	Private Pay - Net Inpatient Revenue	1,440,315	45
46	Medicare - Net Inpatient Revenue	1,366,627	46
47	Other-(specify) Insurance	6,336	47
48	Other-(specify) Hospice	98,877	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,255,551	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 CONSULTANTS' REPORT

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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	1,637	1,734	$ 77,008	$ 44.41	1
2	Assistant Director of Nursing	270	286	11,450	40.03	2
3	Registered Nurses	7,533	8,148	269,744	33.11	3
4	Licensed Practical Nurses	10,540	10,798	301,952	27.96	4
5	CNAs & Orderlies	32,511	33,350	457,336	13.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,348	2,494	37,416	15.00	9
10	Activity Assistants	2,866	3,008	34,753	11.55	10
11	Social Service Workers	1,964	2,067	44,441	21.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,892	4,104	87,440	21.31	17
18	Housekeepers	7,354	7,910	80,265	10.15	18
19	Laundry	1,845	2,073	22,144	10.68	19
20	Administrator	2,117	2,226	87,218	39.18	20
21	Assistant Administrator					21
22	Other Administrative	7,667	8,193	166,997	20.38	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Transportation	2,171	2,316	36,476	15.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	84,715	88,707	$ 1,714,640 *	$ 19.33	34

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		$		35
36	Medical Director	Monthly	17,400	L9, C3	36
37	Medical Records Consultant		1,659	L10, C3	37
38	Nurse Consultant	331	19,437	L10, C3	38
39	Pharmacist Consultant		12,147	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,662	L11, C3	44
45	Social Service Consultant	15	972	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	371	$ 53,277		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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

** See instructions.

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jonas Hoedebecke	Administrator	100	$ 87,218
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 87,218

B. Administrative - Other

Description	Amount
Compliance Consultant	$ 17,102
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 17,102

C. Professional Services

Vendor/Payee	Type	Amount
Accolade Health Care	Management Fees	$ 140,000
Shkop Financial Services	Finance Consultant	4,333
Waxman Associates	Finance Consultant	3,196
ProPay HR	Payroll Processing Fees	16,929
Platinum Billing Solutions	Outsourced Billing Fees	82,300
Global Tech	IT Services	17,809
Marcum	Accounting	17,004
Summitcare	Bookkeeping	13,133
Gutniki	Legal	35,403
Accolade Management	Legal	8,840
John E Zummo	Legal	2,410
Hartweg, Turner, Wood & Devary	Legal	1,188
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 342,545

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,729
Unemployment Compensation Insurance	32,342
FICA Taxes	126,916
Employee Health Insurance	165,446
Employee Meals	8,058
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 367,491

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,149
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,149

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number Accolade Healthcare of Paxton Senior Living # 0054791 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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? **No**
If YES, give association name and amount.

(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?

(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?

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,572** 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.

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **131,489**
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 CONSULTANTS' 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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **172**

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
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? **Yes**
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. $

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

(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