FOR BHF USE

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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.

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

I. IDPH License ID Number: 0054676

Facility Name: Accolade Healthcare of Pontiac

Address: 300 W. Lowell Ave (Number) Pontiac (City) 61764 (Zip Code)

County: Livingston

Telephone Number: (815) 842-1181 **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 Pontiac # 0054676 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	37	Skilled (SNF)	37	13,505	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,900	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,405	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	5,074	1,256	3,055	9,385	8
9	SNF/PED					9
10	ICF	13,770	1,604	555	15,929	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,844	2,860	3,610	25,314	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.50%

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)

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

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

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

I. On what date did you start providing long term care at this location?
Date started 08/02/2017

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/02/2017 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 2,812

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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 Pontiac # 0054676 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		6,028	417,997	424,025		424,025		424,025			1
2	Food Purchase		244		244		244		244			2
3	Housekeeping	1,466	13,144	266,831	281,441		281,441		281,441			3
4	Laundry	478	6,426		6,904		6,904		6,904			4
5	Heat and Other Utilities			110,712	110,712		110,712		110,712			5
6	Maintenance	131,884	58,648	36,688	227,220		227,220	7,169	234,389			6
7	Other (specify):* See attached			63,953	63,953		63,953		63,953			7
8	TOTAL General Services	133,828	84,490	896,181	1,114,499		1,114,499	7,169	1,121,668			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,663,856	127,614	89,100	1,880,570		1,880,570	8,222	1,888,792			10
10a	Therapy			28,797	28,797		28,797		28,797			10a
11	Activities	118,507	5,777	1,564	125,848		125,848		125,848			11
12	Social Services	45,992		1,259	47,251		47,251		47,251			12
13	CNA Training											13
14	Program Transportation	95		19,475	19,570		19,570		19,570			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,828,450	133,391	154,595	2,116,436		2,116,436	8,222	2,124,658			16
	C. General Administration											
17	Administrative	59,337		10,075	69,412		69,412		69,412			17
18	Directors Fees											18
19	Professional Services			383,923	383,923		383,923	(45,581)	338,342			19
20	Dues, Fees, Subscriptions & Promotions			33,244	33,244		33,244	(11,623)	21,621			20
21	Clerical & General Office Expenses	245,806	15,099	99,992	360,897		360,897	(76,118)	284,779			21
22	Employee Benefits & Payroll Taxes			397,563	397,563		397,563	(14,403)	383,160			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,639	14,639		14,639	(14,639)				24
25	Other Admin. Staff Transportation			179	179		179		179			25
26	Insurance-Prop.Liab.Malpractice			100,555	100,555		100,555		100,555			26
27	Other (specify):*											27
28	TOTAL General Administration	305,143	15,099	1,040,170	1,360,412		1,360,412	(162,364)	1,198,048			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,267,421	232,980	2,090,946	4,591,347		4,591,347	(146,973)	4,444,374			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 Pontiac
Line 7 Support
12/31/2018

	Salary/Wage 1	Supplies 2	Other 3	Total 4
Fire & Safety Services	-	-	7,468	7,468
Waste Removal	-	-	43,075	43,075
Landscaping	-	-	11,649	11,649
Exterminator	-	-	1,761	1,761
Total, Line 7	-	-	63,953	63,953

Facility Name & ID Number Accolade Healthcare of Pontiac #0054676 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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			21,945	21,945		21,945	(1,542)	20,403			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			74,782	74,782		74,782	(16)	74,766			32
33	Real Estate Taxes			61,200	61,200		61,200		61,200			33
34	Rent-Facility & Grounds			468,947	468,947		468,947		468,947			34
35	Rent-Equipment & Vehicles			17,884	17,884		17,884	(550)	17,334			35
36	Other (specify):*											36
37	**TOTAL Ownership**			644,758	644,758		644,758	(2,108)	642,650			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			446	446		446		446			38
39	Ancillary Service Centers		98,760	464,241	563,001		563,001		563,001			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			189,513	189,513		189,513		189,513			42
43	Other (specify):* See attached			112,873	112,873		112,873	(76,489)	36,384			43
44	**TOTAL Special Cost Centers**		98,760	767,073	865,833		865,833	(76,489)	789,344			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,267,421	331,740	3,502,777	6,101,938		6,101,938	(225,570)	5,876,368			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 Pontiac
Line 43 Support
12/31/2018

	Salary/Wage 1	Supplies 2	Other 3	Total 4
Laboratory	-	-	32,830	32,830
Radiology	-	-	3,554	3,554
Meals on Wheels	-	-	-	-
Employee personal expenses	-	-	110	110
Advertising & Marketing	-	-	19,791	19,791
Charitable contributions	-	-	7,228	7,228
Start up expenses	-	-	-	-
Penalty and late fees	-	-	1,377	1,377
Theft and loss	-	-	68	68
Bad debt expense	-	-	47,915	47,915
Total, Line 43	-	-	112,873	112,873

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 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				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	(1,542)	30		9
10	Interest and Other Investment Income	(16)	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)	(14,639)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,377)	43		18
19	Entertainment				19
20	Contributions	(7,228)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(54,074)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,915)	43		24
25	Fund Raising, Advertising and Promotional	(19,791)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (146,582)		$	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))**	$ (146,582)		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

Accolade Healthcare of Pontiac

ID# 0054676

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Theft and Loss	$ (68)	43	1
2	Non-Allowable Dues and Subscriptions	(11,623)	20	2
3	Non-Allowable Bank Charges	(2,067)	21	3
4	Auto Lease - Non-Allowable	(2,820)	35	4
5	Marketing Salaries	(82,143)	21	5
6	Marketing Benefits	(14,403)	22	6
7	Personal expenses	(110)	43	7
8	Copier rental fees included in office expense	2,270	35	8
9	Copier rental fees included in office expense	(2,270)	21	9
10	Equipment less than $2,500 capitalization threshold	7,169	6	10
11	Equipment less than $2,500 capitalization threshold	8,222	10	11
12	Equipment less than $2,500 capitalization threshold	4,515	21	12
13	Adjust finance salaries based on total allocated cost	5,847	21	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(87,481)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 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 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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	7,169	0	0	0	0	0	0	0	0	0	0	7,169	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	7,169	0	0	0	0	0	0	0	0	0	0	7,169	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	8,222	0	0	0	0	0	0	0	0	0	0	8,222	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**	8,222	0	0	0	0	0	0	0	0	0	0	8,222	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	(54,074)	8,493	0	0	0	0	0	0	0	0	0	(45,581)	19
20	Fees, Subscriptions & Promotions	(11,623)	0	0	0	0	0	0	0	0	0	0	(11,623)	20
21	Clerical & General Office Expenses	(76,118)	0	0	0	0	0	0	0	0	0	0	(76,118)	21
22	Employee Benefits & Payroll Taxes	(14,403)	0	0	0	0	0	0	0	0	0	0	(14,403)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(14,639)	0	0	0	0	0	0	0	0	0	0	(14,639)	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**	(170,857)	8,493	0	0	0	0	0	0	0	0	0	(162,364)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(155,466)	8,493	0	0	0	0	0	0	0	0	0	(146,973)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 **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	(1,542)	0	0	0	0	0	0	0	0	0	0	(1,542)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16)	0	0	0	0	0	0	0	0	0	0	(16)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(550)	0	0	0	0	0	0	0	0	0	0	(550)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,108)	0	0	0	0	0	0	0	0	0	0	(2,108)	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):*	(76,489)	0	0	0	0	0	0	0	0	0	0	(76,489)	43
44	**TOTAL Special Cost Centers**	(76,489)	0	0	0	0	0	0	0	0	0	0	(76,489)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(234,063)	8,493	0	0	0	0	0	0	0	0	0	(225,570)	45

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 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 Paxton Senior Living	Paxton	Accolade Healthcare, I	Chicago	Management Compa
Shmuel 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	$ 177,000	Accolade Healthcare, LLC	100.00%	$ 185,493	$ 8,493	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			$ 177,000			$ 185,493	$ * 8,493	14

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

SEE CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 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 Pontiac # 0054676 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	15	38.17	Alloc Salary	$ 64,873	L19, C3	1
2	Shmuel Freedman	Owner	Finance	1.00	See attached 7A	15	38.17	Alloc Salary	25,617	L21, C1	2
3	Shmuel Freedman	Owner	Finance	1.00	See attached 7A	15	38.17	Alloc Salary	11,947	L19, C3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 102,437		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 CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 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	5,902,997	$ 185,493	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		$ 185,493	25

SEE CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 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**		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	See Attachment 9A			Cap Ex			$	$			$ 3,542	1
2	See Attachment 9A			Start Up							24,964	2
3	Amortization Expense										19,089	3
4												4
5												5
	Working Capital											
6	Miscellaneous Interest			Operations							5,292	6
7	Bank Financial			Line of Credit							17,994	7
8	See Attachment 9A			Bridge Loan							3,901	8
9	TOTAL Facility Related						$	$			$ 74,782	9
	B. Non-Facility Related*											
10												10
11	Interest Income Offset										(16)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (16)	14
15	TOTALS (line 9+line14)						$	$			$ 74,766	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 Pontiac # 0054676 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.**	$ 60,914	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.)		$ 60,914	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.)		$ 61,200	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.		$ 61,200	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013		8
2014		9
2015		10
2016	61,178	11
2017	60,914	12

Cost Report was not filed in 2017 as change of ownership occurred on 8/2/2017 - used 2017 tax bill paid in 2018 on Line 1.

Current year accrual is based on prior year tax bill.

	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.

SEE CONSULTANTS' REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Accolade Healthcare of Pontiac COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0054676

CONTACT PERSON REGARDING THIS REPORT Sam Freedman

TELEPHONE (973) 557-3339 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.	15-15-27-255-014	Long Term Care Property	$ 60,914.00	$ 60,914.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 60,914.00	$ 60,914.00

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 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 Pontiac # 0054676 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 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	Wiring for computer and server			2017	3,164	316	10	316		422	9
10	Digital Phone and Voicemail System			2017	17,889	1,789	10	1,789		2,534	10
11	Concrete work			2017	6,065	131	40	131		164	11
12	Boiler			2018	3,857	321	10	321		321	12
13	Boiler - gas			2018	3,120	260	10	260		260	13
14	Trane air conditioner			2018	9,815	491	10	491		491	14
15	Water heater			2018	9,364	390	10	390		390	15
16	Cordless antennas			2018	3,450	144	10	144		144	16
17	Heaters			2018	5,572	186	10	186		186	17
18	Countertops			2018	4,752	277	10	277		277	18
19	LVT, Rustic Barn Wood			2018	24,115	773	10	773		773	19
20	Profile Millwork Base			2018	1,120	36	10	36		36	20
21	Entry Tile Removal, Carpet and Porcelain Install			2018	3,625	116	10	116		116	21
22	Demolition and Framing			2018	5,300	170	10	170		170	22
23	Fabricate and Install Reception Desk			2018	9,250	297	10	297		297	23
24	Signature Wall behind Reception Desk			2018	2,000	64	10	64		64	24
25	Lighting Package			2018	7,500	240	10	240		240	25
26	Wallcovering			2018	2,100	67	10	67		67	26
27	Rustic Wood Specialty Wall Finish			2018	3,000	96	10	96		96	27
28	Speaker System, Low Volt			2018	2,000	64	10	64		64	28
29	Window Treatments			2018	4,500	144	10	144		144	29
30	Seating Group			2018	5,000	160	10	160		160	30
31	Electrical			2018	5,977	192	10	192		192	31
32	Freight / Adhesives			2018	1,500	48	10	48		48	32
33	Cubicle Curtains			2018	1,800	58	10	58		58	33
34	Faux Wood Blinds			2018	2,700	87	10	87		87	34
35	Tub Room			2018	15,000	481	10	481		481	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 Pontiac # 0054676 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	LVT Flooring, E-Wing and Lounge	2018	$ 12,617	$ 405	10	$ 405	$	$ 405	37
38	Base, non-profile	2018	720	23	10	23		23	38
39	Design and Drawings - Architect Fees	2018	12,500	401	10	401		401	39
40	Contractor General Conditions	2018	8,500	273	10	273		273	40
41	Painting of doors, handrails, and dining room	2018	6,750	216	10	216		216	41
42	Removal and replacement of pipes	2018	1,144	37	10	37		37	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)		$ 205,766	$ 8,753		$ 8,753	$	$ 9,637	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 Pontiac # 0054676 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	$ 46,961	$ 9,266	$ 9,266	$	5	$ 11,715	71
72	Current Year Purchases	18,724	2,384	2,384		5	2,384	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 65,685	$ 11,650	$ 11,650	$		$ 14,099	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)	$ 271,451	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 20,403	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 20,403	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 23,736	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 Pontiac # 0054676 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: 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	08/2/2017	$ 465,827	3	3	3
4	Additions							4
5								5
6								6
7	TOTAL		97		$ 465,827 **			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: *

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: $ 4,772 Description: Copier (2,582); Dishwasher (2,190)
(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	2017 Ford Starcraft Bus	$ #######	$ 12,562	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 12,562	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 Pontiac # 0054676 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

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	$	2,857	$ 187,840	$	2,857	$ 187,840	1
2	Licensed Speech and Language Development Therapist		hrs		460	28,945		460	28,945	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		3,952	247,456		3,952	247,456	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				98,760		98,760	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			$	7,269	$ 464,241	$ 98,760	7,269	$ 563,001	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

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 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	$ 29,888	$ 29,888	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 81,000)	994,285	994,285	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,906	10,906	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	197,812	197,812	8
9	Other(specify): Due From Former Owner	3,277	3,277	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,236,168	$ 1,236,168	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	214,634	214,634	15
16	Equipment, at Historical Cost	76,722	76,722	16
17	Accumulated Depreciation (book methods)	(25,277)	(25,277)	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	437,588	437,588	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 703,667	$ 703,667	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,939,835	$ 1,939,835	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,353,948	$ 1,353,948	26
27	Officer's Accounts Payable	500,657	500,657	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	112,347	112,347	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	38,144	38,144	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached schedule	120,522	120,522	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,125,618	$ 2,125,618	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	856,699	856,699	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred rent liability	3,120	3,120	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 859,819	$ 859,819	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,985,437	$ 2,985,437	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,045,602)	$ (1,045,602)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,939,835	$ 1,939,835	48

SEE CONSULTANTS' REPORT

***(See instructions.)**

	Operating 1	After Consolidation 2
Line 23:		
Cap Ex Reserve	8,488	8,488
Option Deposit	429,100	429,100
Total Line 23	437,588	437,588
Line 36:		
Accrued Bed Tax	47,965	47,965
Accrued Management Fees	31,800	31,800
Accrued Payroll Taxes	40,757	40,757
Total Line 36	120,522	120,522

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (368,451)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (368,451)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(677,151)	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)**	$ (677,151)	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)**	$ (1,045,602)	24 *

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

SEE CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 6,891,283	1
2	Discounts and Allowances for all Levels	(1,711,421)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,179,862	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	229,933	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 229,933	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	(2,707)	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)**	$ (2,707)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	17,683	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,683	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,424,787	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,114,499	31
32	Health Care	2,116,436	32
33	General Administration	1,360,412	33
	B. Capital Expense		
34	Ownership	644,758	34
	C. Ancillary Expense		
35	Special Cost Centers	676,320	35
36	Provider Participation Fee	189,513	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,101,938	40
41	**Income before Income Taxes (line 30 minus line 40)****	(677,151)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (677,151)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,927,070	44
45	Private Pay - Net Inpatient Revenue	617,516	45
46	Medicare - Net Inpatient Revenue	1,545,823	46
47	Other-(specify) Insurance	(10,300)	47
48	Other-(specify) Hospice	99,753	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,179,862	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

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	1,111	1,147	$ 58,463	$ 50.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,435	15,465	555,245	35.90	3
4	Licensed Practical Nurses	12,288	13,111	388,593	29.64	4
5	CNAs & Orderlies	41,537	44,190	661,555	14.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,971	2,086	42,801	20.52	9
10	Activity Assistants	7,254	7,957	75,706	9.51	10
11	Social Service Workers	2,016	2,079	45,992	22.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,328	3,533	131,884	37.33	17
18	Housekeepers	144	154	1,466	9.52	18
19	Laundry	40	45	478	10.62	19
20	Administrator					20
21	Assistant Administrator	1,604	1,637	59,337	36.25	21
22	Other Administrative	10,101	10,833	223,677	20.65	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	6	6	95	15.83	32
33	Other(specify) Admissions	823	885	22,129	25.00	33
34	TOTAL (lines 1 - 33)	96,658	103,128	$ 2,267,421 *	$ 21.99	34

SEE CONSULTANTS' REPORT

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	14,400	L9, C3	36
37	Medical Records Consultant		1,793	L10, C3	37
38	Nurse Consultant	416	24,461	L10, C3	38
39	Pharmacist Consultant		19,554	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	24	1,564	L11, C3	44
45	Social Service Consultant	19	1,259	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	459	$ 63,031		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	17	759	L10, C3	51
52	Certified Nurse Assistants/Aides	283	9,064	L10, C3	52
53	TOTAL (lines 50 - 52)	300	$ 9,823		53

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

** See instructions.

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Moshe Freedman	Administrator	99	$ 0
	Asst. Administrator		59,337
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 59,337

B. Administrative - Other

Description	Amount
Compliance Consultant	$ 10,075
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 10,075

C. Professional Services

Vendor/Payee	Type	Amount
Accolade Health Care	Management Fees	$ 177,000
Shkop Financial Services	Finance Consultant	4,333
Waxman Associates	Finance Consultant	1,015
ProPay HR	Payroll Processing Fees	21,093
Platinum Billing Solutions	Outsourced Billing Fees	78,495
Global Tech	IT Services	16,798
Marcum	Accounting	17,982
Summitcare	Bookkeeping	13,133
Gutniki	Legal	32,182
Accolade Management	Legal	9,408
John E Zummo / Frankel Rubin	Legal	4,684
Meyer Magence	Legal	7,800
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 383,923

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,948
Unemployment Compensation Insurance	41,556
FICA Taxes	168,431
Employee Health Insurance	129,192
Employee Meals	5,436
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 397,563

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	21,621
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)	$ 21,621

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.

SEE CONSULTANTS' REPORT

Facility Name & ID Number Accolade Healthcare of Pontiac # 0054676 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. $ **25,329** 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. $ **189,513**
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