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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0054676

Facility Name: Accolade Healthcare Pontiac

Address: 300 West Lowell (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 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Moshe Freedman
(Title) President

Paid Preparer

(Signed) See attached report (Date)
(Print Name and Title) Adam Slavens, Manager
(Firm Name & Address) Baker Tilly US, 225 South Sixth Street, Suite 2300, Minneapolis, MN 55402
(Telephone) 612) 876 4586 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,349	1,677	3,562	10,588	8
9	SNF/PED					9
10	ICF	14,335	1,693	1,008	17,036	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,684	3,370	4,570	27,624	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.81%

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? Y

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 3,496

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: _____ Fiscal Year: _____

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	290,341	28,211	17,450	336,002	5,154	341,156	0	341,156			1
2	Food Purchase		173,142		173,142	-	173,142	(1,873)	171,269			2
3	Housekeeping	192,416	32,884	10,750	236,050	4,190	240,240	0	240,240			3
4	Laundry	55,090	15,530	0	70,620	1,032	71,652	0	71,652			4
5	Heat and Other Utilities			131,600	131,600	-	131,600	0	131,600			5
6	Maintenance	117,076	34,642	21,692	173,410	959	174,369	3,845	178,214			6
7	Other (specify):* See Att			64,736	64,736		64,736	0	64,736			7
8	TOTAL General Services	654,923	284,409	246,228	1,185,560	11,335	1,196,895	1,972	1,198,867			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000	-	15,000	0	15,000			9
10	Nursing and Medical Records	1,972,162	160,883	52,472	2,185,517	17,461	2,202,978	0	2,202,978			10
10a	Therapy			6,349	6,349	-	6,349	0	6,349			10a
11	Activities	124,462	10,462	3,966	138,890	2,066	140,956	0	140,956			11
12	Social Services	52,934		1,584	54,518	575	55,093	0	55,093			12
13	CNA Training				0	-	0	0	0			13
14	Program Transportation	25,573		18,890	44,463	(11,111)	33,352	0	33,352			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	2,175,131	171,345	98,261	2,444,737	8,991	2,453,728	0	2,453,728			16
	C. General Administration											
17	Administrative	112,440		14,235	126,675	931	127,606	0	127,606			17
18	Directors Fees				0	-	0	0	0			18
19	Professional Services			551,446	551,446	-	551,446	(142,616)	408,830			19
20	Dues, Fees, Subscriptions & Promotions			22,385	22,385	-	22,385	(14,696)	7,689			20
21	Clerical & General Office Expenses	272,145	18,065	121,804	412,014	(37,149)	374,865	(62,816)	312,049			21
22	Employee Benefits & Payroll Taxes			389,126	389,126		389,126	(7,488)	381,638			22
23	Inservice Training & Education			7,424	7,424		7,424	0	7,424			23
24	Travel and Seminar			4,045	4,045		4,045	(4,045)	0			24
25	Other Admin. Staff Transportation			75	75		75	0	75			25
26	Insurance-Prop.Liab.Malpractice			161,202	161,202		161,202	0	161,202			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	384,585	18,065	1,271,742	1,674,392	(36,218)	1,638,174	(231,661)	1,406,513			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,214,639	473,819	1,616,231	5,304,689	(15,892)	5,288,797	(229,689)	5,059,108			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Accolade Healthcare of Pontiac
Line 7 Support
12/31/2020

	Salary/Wage	Supplies	Other	Total
	1	2	3	4
Security Consultant	-	-	-	**-**
Fire & Safety Services	-	-	**17,322**	**17,322**
Waste Removal	-	-	**34,646**	**34,646**
Landscaping	-	-	**10,308**	**10,308**
Exterminator	-	-	**2,460**	**2,460**
Total, Line 7	-	-	64,736	**64,736**

Accolade Healthcare of Pontiac
Line 23 Support
12/31/2020

	Salary/Wage	Supplies	Other	Total
	1	2	3	4
Continuing Education	-	-	**7,424**	**7,424**
Total, Line 23	-	-	**7,424**	**7,424**

Description	**Individuals**	**Amount**
CNA Inservice Training	CNAs	4,300
Nursing School Tution	RNs	2,100
Various Trainings	Employees across various disciplines	1,024
	Total	7,424

Facility Name & ID Number Accolade Healthcare Pontiac #0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			58,850	58,850		58,850	(10,042)	48,808			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			138,150	138,150		138,150	(370)	137,780			32
33	Real Estate Taxes			61,200	61,200		61,200	0	61,200			33
34	Rent-Facility & Grounds			405,074	405,074		405,074	0	405,074			34
35	Rent-Equipment & Vehicles			3,677	3,677	15,892	19,569	(1,669)	17,900			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			666,951	666,951	15,892	682,843	(12,081)	670,762			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			116	116		116	0	116			38
39	Ancillary Service Centers		92,216	464,525	556,741		556,741	0	556,741			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			200,421	200,421		200,421	0	200,421			42
43	Other (specify):* See Att			234,963	234,963		234,963	(202,420)	32,543			43
44	**TOTAL Special Cost Centers**	0	92,216	900,025	992,241	0	992,241	(202,420)	789,821			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,214,639	566,035	3,183,207	6,963,881	0	6,963,881	(444,190)	6,519,691			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Accolade Healthcare of Pontiac
Line 43 Support
12/31/2020

	Salary/Wage 1	Supplies 2	Other 3	Total 4
Laboratory	-	-	**1,545**	**1,545**
Lab - Medicare	-	-	**24,697**	**24,697**
Lab - Medicare Replacement	-	-	**101**	**101**
Radiology	-	-	**-**	**-**
Radiology - Medicare	-	-	**6,200**	**6,200**
Meals on Wheels	-	-	**-**	**-**
Employee personal expenses	-	-	**-**	**-**
Advertising & Marketing	-	-	**21,474**	**21,474**
Charitable contributions	-	-	**15,088**	**15,088**
Start up expenses	-	-	**-**	**-**
Penalty and late fees	-	-	**-**	**-**
Theft and loss	-	-	**91**	**91**
Bad debt expense	-	-	**165,767**	**165,767**
Total, Line 43	**-**	**-**	**234,963**	**234,963**

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(370)	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)	(4,045)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(91)	43		18
19	Entertainment				19
20	Contributions	(15,088)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(34,476)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(165,767)	43		24
25	Fund Raising, Advertising and Promotional	(21,474)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (241,311)		$ 0	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)	(54,070)	19	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (54,070)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (295,381)		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 ACCOUNTANTS' PREPARATION REPORT

Accolade Healthcare Pontiac

ID# 0054676

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaenous Income	$ (2,901)	21	1
2	Marketing Salaries	(61,860)	21	2
3	Marketing Benefits	(7,488)	22	3
4	Equipment/BI below $2,500 capitalization threshold:	3,845	6	4
5	Equipment/BI below $2,500 capitalization threshold:	2,556	21	5
6	Depreciation for items below capitalization threshold	(8,919)	30	6
7	Non-Allowable Dues and Subscriptions	(14,696)	20	7
8	Non-Allowable Bank Charges	(611)	21	8
9	Auto Lease - Non-Allowable	(1,669)	35	9
10	Auto Depreciation - Non-Allowable	(1,123)	30	10
11	Sales tax on food	(1,873)	2	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(94,739)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(1,873)	0	0	0	0	0	0	0	0	0	0	(1,873)	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	3,845	0	0	0	0	0	0	0	0	0	0	3,845	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,972	0	0	0	0	0	0	0	0	0	0	1,972	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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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	(88,546)	(54,070)	0	0	0	0	0	0	0	0	0	(142,616)	19
20	Fees, Subscriptions & Promotions	(14,696)	0	0	0	0	0	0	0	0	0	0	(14,696)	20
21	Clerical & General Office Expenses	(62,816)	0	0	0	0	0	0	0	0	0	0	(62,816)	21
22	Employee Benefits & Payroll Taxes	(7,488)	0	0	0	0	0	0	0	0	0	0	(7,488)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,045)	0	0	0	0	0	0	0	0	0	0	(4,045)	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**	(177,591)	(54,070)	0	0	0	0	0	0	0	0	0	(231,661)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(175,619)	(54,070)	0	0	0	0	0	0	0	0	0	(229,689)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Accolade Healthcare Pontiac **#** 0054676 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(10,042)	0	0	0	0	0	0	0	0	0	0	(10,042)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(370)	0	0	0	0	0	0	0	0	0	0	(370)	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	(1,669)	0	0	0	0	0	0	0	0	0	0	(1,669)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,081)	0	0	0	0	0	0	0	0	0	0	(12,081)	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):*	(202,420)	0	0	0	0	0	0	0	0	0	0	(202,420)	43
44	**TOTAL Special Cost Centers**	(202,420)	0	0	0	0	0	0	0	0	0	0	(202,420)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(390,120)	(54,070)	0	0	0	0	0	0	0	0	0	(444,190)	45

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Moshe Freedman	99%	Accolade Healthcare of Paxton Senior Living	Paxton	Accolade Healthcare, I	Chicago	Management Compa
Shmuel Freedman	1%	Accolade Healthcare of the Heartland	Paxton			
		Accolade Healthcare of the Danville	Danville			

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	$ 345,300	Accolade Healthcare, LLC	100.00%	$ 291,230	$ (54,070)	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			$ 345,300			$ 291,230	$ * (54,070)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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 ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Shmuel Freedman	Owner	Finance	1.00	See Attached 7A	12	30.98	Alloc Salary	$ 47,562	L19, C3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 47,562		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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	21,361,753	5	$ 939,956	$ 392,030	6,618,581	$ 291,230	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					$ 939,956	$ 392,030		$ 291,230	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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 Attached 9A						$ 180,000	$ 103,740			$ 8,450	1
2	See Attached 9A						500,657	500,657			25,032	2
3	See Attached 9A						200,000	106,320			19,527	3
4	Amortization Expense										10,100	4
5												5
	Working Capital											
6	Misc Interest & Loan Acquisition Expense										10,352	6
7	See Attached 9A							10,379			64,689	7
8	See Attached 9A						174,600	101,850				8
9	TOTAL Facility Related						$ 1,055,257	$ 822,946			$ 138,150	9
	B. Non-Facility Related*											
10												10
11	Interest Income Offset										(370)	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ (370)	14
15	TOTALS (line 9+line14)						$ 1,055,257	$ 822,946			$ 137,780	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 ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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.)		$ 61,200	2
3. Under or (over) accrual (line 2 minus line 1).		$ 61,200	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 61,200	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015		8
2016	61,178	9
2017	60,914	10
2018	71,291	11
2019	71,092	12

Real Estate taxes paid in current year is based on 2017 tax year.
No accrual in current year as taxes are paid to landlord on a monthly basis.
Landlord pays real estate taxes and Accolade remits payments to the Landlord in turn.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Accolade Healthcare 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 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) 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	$ 71,092.00	$ 71,092.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 71,092.00	$ 71,092.00

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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? [ ] (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			$ 0	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wiring for computer and server			2017	3,164	316	10	316		1,054	9
10	Digital Phone and Voicemail System			2017	17,889	1,789	10	1,789		6,112	10
11	Concrete work			2017	6,065	152	40	152		468	11
12	Boiler			2018	3,857	386	10	386		1,093	12
13	Boiler - gas			2018	3,120	312	10	312		884	13
14	Trane air conditioner			2018	9,815	981	10	981		2,453	14
15	Water heater			2018	9,364	936	10	936		2,262	15
16	Cordless antennas			2018	3,450	345	10	345		834	16
17	Heaters			2018	5,572	557	10	557		1,300	17
18	Countertops			2018	4,752	476	10	476		1,229	18
19	LVT, Rustic Barn Wood			2018	24,115	2,411	10	2,411		5,595	19
20	Profile Millwork Base			2018	1,120	112	10	112		260	20
21	Entry Tile Removal, Carpet and Porcelain Install			2018	3,625	362	10	362		840	21
22	Demolition and Framing			2018	5,300	530	10	530		1,230	22
23	Fabricate and Install Reception Desk			2018	9,250	925	10	925		2,147	23
24	Signature Wall behind Reception Desk			2018	2,000	200	10	200		464	24
25	Lighting Package			2018	7,500	750	10	750		1,740	25
26	Wallcovering			2018	2,100	210	10	210		487	26
27	Rustic Wood Specialty Wall Finish			2018	3,000	300	10	300		696	27
28	Speaker System, Low Volt			2018	2,000	200	10	200		464	28
29	Window Treatments			2018	4,500	450	10	450		1,044	29
30	Seating Group			2018	5,000	500	10	500		1,160	30
31	Electrical			2018	5,977	598	10	598		1,388	31
32	Freight / Adhesives			2018	1,500	150	10	150		348	32
33	Cubicle Curtains			2018	1,800	180	10	180		418	33
34	Faux Wood Blinds			2018	2,700	270	10	270		627	34
35	Tub Room			2018	15,000	1,500	10	1,500		3,481	35
36	LVT Flooring, E-Wing and Lounge			2018	12,617	1,262	10	1,262		2,929	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Base, non-profile	2018	$ 720	$ 72	10	$ 72	$	$ 167	37
38	Design and Drawings - Architect Fees	2018	12,500	1,250	10	1,250		2,901	38
39	Contractor General Conditions	2018	8,500	850	10	850		1,973	39
40	Painting of doors, handrails, and dining room	2018	6,750	675	10	675		1,566	40
41	Removal and replacement of pipes	2018	1,144	114	10	114		265	41
42	Commercial Garbage Disposal	2019	2,986	332	9	332		388	42
43	Central Air System	2019	13,617	1,513	9	1,513		1,766	43
44	Dialysis room flooring	2019	2,122	236	9	236		78	44
45	Dialysis room	2019	4,523	503	9	503		168	45
46	Door for dialysis room	2019	1,640	182	9	182		30	46
47	Reach-in freezer	2019	4,297	477	9	477		240	47
48	Water circulation Pipe	2020	2,940	367	8	367		367	48
49	Nurse Call Light system - TekTone LS160 Tek-CARE160	2020	58,174	4,242	8	4,242		4,242	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)		$ 296,065	$ 27,973		$ 27,973	$ 0	$ 57,158	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 79,986	$ 16,052	$ 16,052	$ 0	5	$ 43,677	71
72	Current Year Purchases	50,842	4,783	4,783	0	5	4,783	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 130,828	$ 20,835	$ 20,835	$ 0		$ 48,460	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				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	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)	$ 426,893	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 48,808	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 48,808	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 105,618	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.

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	8/2/17	$ 405,074	3	3	3
4	Additions							4
5								5
6								6
7	TOTAL		97		$ 405,074 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 3,658
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: [ ] YES [X] 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.	12/31/21	$ 411,451
13.	12/31/22	$ 421,737
14.	12/31/23	$ 432,281

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

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

16. Rental Amount for movable equipment: $ 6,385 Description: Copier (4,377); Dishwasher (2,008)
(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	$ #######	$ 11,515	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 11,515	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	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	$	2,015	$ 156,787	$	2,015	$ 156,787	1
2	Licensed Speech and Language Development Therapist		hrs		664	55,953		664	55,953	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,522	197,554		2,522	197,554	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				92,216		92,216	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp. Therapist				168	12,107		168	12,107	12
13	Other (specify):									13
14	TOTAL			$	5,369	$ 422,401	$ 92,216	5,369	$ 514,617	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.

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Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,396	$ 1,396	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 149,000)	1,046,139	1,046,139	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,129	24,129	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	447,973	447,973	8
9	Other(specify): Accrued Revenue	227,440	227,440	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,747,077	$ 1,747,077	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	316,749	316,749	15
16	Equipment, at Historical Cost	177,736	177,736	16
17	Accumulated Depreciation (book methods)	(126,691)	(126,691)	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	488,221	488,221	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 856,015	$ 856,015	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,603,092	$ 2,603,092	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 751,432	$ 751,432	26
27	Officer's Accounts Payable	500,657	500,657	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	180,588	180,588	29
30	Accrued Salaries Payable	113,646	113,646	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,763	27,763	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	85,060	85,060	33
34	Deferred Compensation	237,561	237,561	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,285,210	1,285,210	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,181,917	$ 3,181,917	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	37,961	37,961	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 37,961	$ 37,961	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,219,878	$ 3,219,878	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (616,786)	$ (616,786)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,603,092	$ 2,603,092	48

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*(See instructions.)

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	Operating	After Consolidation
Line 23:	1	2
Loan Acquisition Costs	37,025.00	37,025.00
Deferred MCO Contract Expense	18,200.00	18,200.00
ACCUM.AMORT LOAN ACQ COSTS	(19,657.00)	(19,657.00)
ACCUM.AMORT OF MCO CONTRACTS	(14,900.00)	(14,900.00)
Cap Ex Reserve	38,453.00	38,453.00
Option Deposit	429,100.00	429,100.00
Total Line 23	**488,221.00**	**488,221.00**

Line 36:		
Due to Affiliate	(1,108,544.00)	(1,108,544.00)
Accrued Bed Tax	(52,700.00)	(52,700.00)
CAPEX LOAN - LANDLORD	(103,740.00)	(103,740.00)
DEFERRED RENT LIABILITY	(20,226.00)	(20,226.00)
Total Line 36	**1,285,210.00**	**1,285,210.00**

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,854,011)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,854,011)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,237,225	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)**	$ 1,237,225	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (616,786)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,588,983	1
2	Discounts and Allowances for all Levels	(3,845,995)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,742,988	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	159,121	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 159,121	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	370	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 370	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	2,901	28
28a	COVID PHE	1,295,726	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,298,627	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,201,106	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,185,560	31
32	Health Care	2,444,737	32
33	General Administration	1,674,392	33
	B. Capital Expense		
34	Ownership	666,951	34
	C. Ancillary Expense		
35	Special Cost Centers	791,820	35
36	Provider Participation Fee	200,421	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,963,881	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,237,225	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,237,225	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,521,493	44
45	Private Pay - Net Inpatient Revenue	767,482	45
46	Medicare - Net Inpatient Revenue	2,339,696	46
47	Other-(specify) Hospice	114,317	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,742,988	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,859	2,016	$ 95,032	$ 47.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,870	10,909	428,354	39.27	3
4	Licensed Practical Nurses	16,947	18,170	556,196	30.61	4
5	CNAs & Orderlies	51,587	54,796	910,041	16.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,013	2,106	47,757	22.68	9
10	Activity Assistants	6,493	6,893	78,771	11.43	10
11	Social Service Workers	2,162	2,269	53,509	23.58	11
12	Dietician					12
13	Food Service Supervisor	2,020	2,132	49,755	23.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,013	21,316	245,740	11.53	15
16	Dishwashers					16
17	Maintenance Workers	2,043	2,104	118,035	56.10	17
18	Housekeepers	14,581	15,563	196,606	12.63	18
19	Laundry	4,533	5,048	56,122	11.12	19
20	Administrator	2,000	2,084	113,371	54.40	20
21	Assistant Administrator					21
22	Other Administrative	12,308	12,900	239,374	18.56	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 Care(specify)					32
33	Other(specify) Transportation	1,933	2,073	25,976	12.53	33
34	TOTAL (lines 1 - 33)	150,362	160,379	$ 3,214,639 *	$ 20.04	34

SEE ACCOUNTANTS' PREPARATION 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	15,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	359	21,076	L10, C3	38
39	Pharmacist Consultant		17,991	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	1,584	L11, C3	44
45	Social Service Consultant	24	1,584	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	407	$ 57,235		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

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

** See instructions.

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Malerie L Orsowy	Administrator	0	$ 112,440
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 112,440

B. Administrative - Other

Description	Amount
Compliance Consultant	$ 14,235
TOTAL (agree to Schedule V, line 17, col. 3)	$ 14,235
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ProPayHR	Payroll Processing Fees	$ 19,507
Platinum Billing Solutions	Outsourced Billing	83,520
Various Private Payors	Amortized Contracual Adjustme	9,100
STL Bookeeping	Bookeeping	443
Global Tech Solutions	IT	20,336
Various (See Support)	Legal	23,865
RubinBrown LLP	Accounting	21,875
Accolade Management	Management Fees	345,300
Settlement Fees (Offset)	Legal	27,500
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 551,446

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,897
Unemployment Compensation Insurance	53,372
FICA Taxes	231,476
Employee Health Insurance	53,437
Employee Meals	5,304
Illinois Municipal Retirement Fund (IMRF)*	
Safe Harbor Match	6,640
Unallowable Marketing Benefits	(7,488)
TOTAL (agree to Schedule V, line 22, col.8)	$ 381,638

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	7,689
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)	$ 7,689

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 ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade Healthcare Pontiac # 0054676 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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. $ **34,341** 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. $ **200,421**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **None in CY** Indicate the amount. $

(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. $ **N/A**

(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 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.