

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0055004</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Accolade HC Paxton on Pells</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> 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.																							
Address: <u>1001 East Pells St</u> <u>Paxton</u> <u>60957</u>																									
Number City Zip Code																									
County: <u>Ford</u>																									
Telephone Number: <u>(217) 379-4361</u> Fax # ()																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Moshe Freedman</u></td></tr><tr><td>(Title) <u>President</u></td></tr><tr><td>(Signed) <u>See Attached Report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Adam Slavens Manager</u></td></tr><tr><td>(Firm Name & Address) <u>Baker Tilly US, LLP 225 South Sixth Street, Suite 2300, Minneapolis, MN 55402</u></td></tr><tr><td>(Telephone) <u>(612) 876 4586</u> Fax # ()</td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Moshe Freedman</u>	(Title) <u>President</u>	(Signed) <u>See Attached Report</u>	Paid Preparer	(Print Name and Title) <u>Adam Slavens Manager</u>	(Firm Name & Address) <u>Baker Tilly US, LLP 225 South Sixth Street, Suite 2300, Minneapolis, MN 55402</u>	(Telephone) <u>(612) 876 4586</u> 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												
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	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																								
Date of Initial License for Current Owners: <u>05/02/2018</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☒ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☒ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Sam Freedman</u> Telephone Number: <u>(973) 557-3339</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade HC Paxton on Pells

0055004 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>106</u>	Skilled (SNF)	<u>106</u>	<u>38,796</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>106</u>	TOTALS	<u>106</u>	<u>38,796</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>23,207</u>	<u>3,993</u>	<u>6,079</u>	<u>33,279</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,207</u>	<u>3,993</u>	<u>6,079</u>	<u>33,279</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.78%

SEE ACCOUNTANTS' PREPARATION REPORT

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)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/02/2018

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 10/17/2018 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 106 and days of care provided 1,751

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Accolade HC Paxton on Pells # 0055004 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 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	345,535	38,643	10,202	394,380	7,885	402,265	967	403,232			1
2	Food Purchase		246,921		246,921	-	246,921	(2,412)	244,509			2
3	Housekeeping	212,980	25,495	18,275	256,750	10,885	267,635	0	267,635			3
4	Laundry	48,793	13,902	0	62,695	528	63,223	0	63,223			4
5	Heat and Other Utilities			125,350	125,350	-	125,350	0	125,350			5
6	Maintenance	75,822	25,687	13,944	115,453	1,315	116,768	3,399	120,167			6
7	Other (specify):*			46,401	46,401	-	46,401	0	46,401			7
8	TOTAL General Services	683,130	350,648	214,172	1,247,950	20,613	1,268,563	1,954	1,270,517			8
	B. Health Care and Programs											
9	Medical Director			57,000	57,000		57,000	0	57,000			9
10	Nursing and Medical Records	2,335,443	238,680	64,296	2,638,419	33,257	2,671,676	5,724	2,677,400			10
10a	Therapy			17,123	17,123	-	17,123	0	17,123			10a
11	Activities	109,276	9,231	6,670	125,177	2,047	127,224	0	127,224			11
12	Social Services	99,065		3,168	102,233	1,584	103,817	0	103,817			12
13	CNA Training				0	-	0	0	0			13
14	Program Transportation	35,520		20,737	56,257	(11,932)	44,325	0	44,325			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	2,579,304	247,911	168,994	2,996,209	24,956	3,021,165	5,724	3,026,889			16
	C. General Administration											
17	Administrative	124,717		9,000	133,717	1,860	135,577	0	135,577			17
18	Directors Fees				0	-	0	0	0			18
19	Professional Services			596,922	596,922	-	596,922	(169,017)	427,905			19
20	Dues, Fees, Subscriptions & Promotions			16,665	16,665	-	16,665	(7,745)	8,920			20
21	Clerical & General Office Expenses	358,164	18,406	125,277	501,847	(59,997)	441,850	(72,668)	369,182			21
22	Employee Benefits & Payroll Taxes			538,967	538,967		538,967	(9,997)	528,970			22
23	Inservice Training & Education			10,217	10,217		10,217	0	10,217			23
24	Travel and Seminar			3,892	3,892		3,892	(3,892)	0			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			122,023	122,023		122,023	0	122,023			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	482,881	18,406	1,422,963	1,924,250	(58,137)	1,866,113	(263,319)	1,602,794			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,745,315	616,965	1,806,129	6,168,409	(12,568)	6,155,841	(255,641)	5,900,200			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 HC Paxton on Pells
12/31/2020
Line 23 Detail

	Salary/Wage 1	Supplies 2	Other 3	Total 4
Continuing Education	-	-	10,217	10,217
Total, Line 23	-	-	10,217	10,217

<u>Description</u>	<u>Employees</u>	<u>Amount</u>
Software for Employee Training CNA Inservice	CNAs	5,900
Employee Training and Continuing Ed	Employees across numerous disciplines	4,317
		10,217

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			27,408	27,408		27,408	(3,565)	23,843			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			82,023	82,023		82,023	(78)	81,945			32
33	Real Estate Taxes			83,158	83,158		83,158	0	83,158			33
34	Rent-Facility & Grounds			540,098	540,098		540,098	0	540,098			34
35	Rent-Equipment & Vehicles				0	12,568	12,568	0	12,568			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			732,687	732,687	12,568	745,255	(3,643)	741,612			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,087	1,087		1,087	0	1,087			38
39	Ancillary Service Centers		72,883	363,239	436,122		436,122	0	436,122			39
40	Barber and Beauty Shops			1,688	1,688		1,688	0	1,688			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			248,422	248,422		248,422	0	248,422			42
43	Other (specify):*			192,654	192,654		192,654	(184,284)	8,370			43
44	TOTAL Special Cost Centers	0	72,883	807,090	879,973	0	879,973	(184,284)	695,689			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,745,315	689,848	3,345,906	7,781,069	0	7,781,069	(443,568)	7,337,501			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

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	(44)	1		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	(78)	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)	(3,892)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	43		18
19	Entertainment				19
20	Contributions	(15,745)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,215)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(141,909)	43		24
25	Fund Raising, Advertising and Promotional	(22,463)	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)	\$ (190,776)		\$ 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)	(81,901)	19	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (81,901)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (272,677)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (839)	21	1
2	Marketing Salaries	(69,471)	21	2
3	Marketing Benefits	(9,997)	22	3
4	Theft and Loss	(2,737)	43	4
5	Equipment below \$2,500 capitalization threshold:	3,399	6	5
6	Equipment below \$2,500 capitalization threshold:	5,724	10	6
7	Equipment below \$2,500 capitalization threshold:	520	21	7
8	Marketing Auto Depreciaton- Non-Allowable	(1,148)	30	8
9	Non-Allowable Dues and Subscriptions	(7,745)	20	9
10	Non-Allowable Bank Charges	(2,878)	21	10
11	Sales tax on food	(2,412)	2	11
12	Equipment below \$2,500 capitalization threshold:	1,011	1	12
13	Depr Adj	(2,417)	30	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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27				27
28				28
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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	(88,990)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Accolade HC Paxton on Pells# 0055004

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	967	0	0	0	0	0	0	0	0	0	0	967	1
2	Food Purchase	(2,412)	0	0	0	0	0	0	0	0	0	0	(2,412)	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	3,399	0	0	0	0	0	0	0	0	0	0	3,399	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,954	0	0	0	0	0	0	0	0	0	0	1,954	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	5,724	0	0	0	0	0	0	0	0	0	0	5,724	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	5,724	0	0	0	0	0	0	0	0	0	0	5,724	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	(87,116)	(81,901)	0	0	0	0	0	0	0	0	0	(169,017)	19
20	Fees, Subscriptions & Promotions	(7,745)	0	0	0	0	0	0	0	0	0	0	(7,745)	20
21	Clerical & General Office Expenses	(72,668)	0	0	0	0	0	0	0	0	0	0	(72,668)	21
22	Employee Benefits & Payroll Taxes	(9,997)	0	0	0	0	0	0	0	0	0	0	(9,997)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,892)	0	0	0	0	0	0	0	0	0	0	(3,892)	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	(181,418)	(81,901)	0	0	0	0	0	0	0	0	0	(263,319)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(173,740)	(81,901)	0	0	0	0	0	0	0	0	0	(255,641)	29

Summary B

12/31/2020

[illegible]

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.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Moshe Freedman	98%	Accolade Healthcare of Pontiac	Pontiac	Accolade Healthcare, I	Chicago	Management Compa
Shmuel Freedman	2%	Accolade Healthcare of Paxton Senior Living	Paxton			
		Accolade Healthcare of 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.

☐ 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.

1Schedule V		2Line	3Cost Per General Ledger	4Amount	5Cost to Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	19	Management Fees	\$ 406,400	Accolade Healthcare, LLC	100.00%	\$ 324,499	\$ (81,901)	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			\$ 406,400			\$ 324,499	\$ * (81,901)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Shmuel Freedman	Owner	Finance	2.00	See Attached 7A	14	34.52	Alloc Salary	\$ 52,995	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	\$ 52,995		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 HC Paxton on Pells# 0055004 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 ☒ NO ☐

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

Name of Related Organization Accolade Health
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	7,374,669	\$ 324,499	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		\$ 324,499	25

SEE ACCOUNTANTS' PREPARATION REPORT

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						\$ 300,000	\$ 300,000			\$ 15,000	1
2	See Attachment 9A							141,759			10,351	2
3	See Attachment 9A						344,000	40,000				3
4	Amortization Expense										11,377	4
5												5
	Working Capital											
6	See Attachment 9A							13,838			38,348	6
7	Miscellaneous Interest & Loan Acqu										6,947	7
8	See Attachment 9A						220,500	128,625				8
9	TOTAL Facility Related						\$ 864,500	\$ 624,222			\$ 82,023	9
	B. Non-Facility Related*											
10												10
11	Interest Income Offset										(78)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ (78)	14
15	TOTALS (line 9+line14)						\$ 864,500	\$ 624,222			\$ 81,945	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.)

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 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.)				\$	83,1582
3. Under or (over) accrual (line 2 minus line 1).				\$	83,1583
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.				\$	83,1587
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015		8	
		2016		9	
		2017	83,158	10	
		2018	71,327	11	
		2019	72,330	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.					

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 HC Paxton on Pells COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0055004

CONTACT PERSON REGARDING THIS REPORT Sam Freedman

TELEPHONE () 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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-14-08-476-001</u>	<u>Nursing Home</u>	\$ <u>72,330.00</u>	\$ <u>72,330.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>72,330.00</u></u>	\$ <u><u>72,330.00</u></u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,285

B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$ 0	3

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Repair walls		2018		3,200	320	10	320		693
10	North & South hallway hall repairs		2018		4,600	460	10	460		997
11	West hallway hall repairs		2018		2,500	250	10	250		542
12	North & South hallway skim coat		2018		1,650	165	10	165		344
13	West hallway skim coat		2018		3,050	305	10	305		635
14	2 - 90 minute Fire rated Doors		2019		3,208	356	9	356		712
15	Full Building Wallpaper removal and painting		2019		10,700	1,189	9	1,189		2,279
16										16
17										17
18	Repair Fire Sprinkler system		2020		14,467	1,507	8	1,507		1,507
19	Vinyl Flooring for half the building		2020		34,409	2,509	8	2,509		2,509
20										20
21	Air Conditioner		2020		25,185	1,312	8	1,312		1,312
22	Call Light System		2020		42,827	2,231	8	2,231		2,231
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 145,796	\$ 10,604		\$ 10,604	\$ 0	\$ 13,761	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$49,926	\$9,986	\$9,986	\$0	5	\$21,940	71
72	Current Year Purchases	38,404	3,253	3,253	0	5	3,253	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$88,330	\$13,239	\$13,239	\$0		\$25,193	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	2	
		Reference			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)			\$234,126	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$23,843	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$23,843	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)			\$38,954	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Paradox Paxton Property, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		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:	1988	106	10/1/17	\$540,098	3	3	3
4	Additions							4
5								5
6								6
7	TOTAL		106		\$540,098			7

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

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

36 mo

.

4,877

1,620,293

9. Option to Buy:

☐ YES

☒ NO

Terms:_____*

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

15. Is Movable equipment rental included in building rental?

☐ YES

☒ NO
16. Rental Amount for movable equipment: \$_____Description:_____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2017 FORD Econoline	\$#####	\$12,568	17
18					18
19					19
20					20
21	TOTAL		\$#####	\$12,568	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.

10. Effective dates of current rental agreement:

Beginning10/17/18

Ending10/30/21

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

	Fiscal Year Ending	Annual Rent
12.	12/31/21	\$548,601
13.	12/31/22	\$562,316
14.	12/31/23	\$576,374

SEE ACCOUNTANTS' PREPARATION REPORT

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

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			

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

\$

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.)

12345678										
	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	\$	1,908	\$ 134,899	\$	1,908	\$ 134,899	1
2	Licensed Speech and Language Development Therapist		hrs		478	38,777		478	38,777	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,391	185,624		2,391	185,624	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				72,883		72,883	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp. Therapy				66	4,299		66	4,299	12
13	Other (specify):									13
14	TOTAL			\$	4,843	\$ 363,599	\$ 72,883	4,843	\$ 436,482	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 833	\$ 833	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 177,000)	1,279,605	1,279,605	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,109	21,109	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Detail	1,518,058	1,518,058	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,819,605	\$ 2,819,605	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	152,407	152,407	15
16	Equipment, at Historical Cost	111,426	111,426	16
17	Accumulated Depreciation (book methods)	(43,225)	(43,225)	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 Detail	420,561	420,561	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 641,169	\$ 641,169	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,460,774	\$ 3,460,774	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 539,052	\$ 539,052	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	233,609	233,609	29
30	Accrued Salaries Payable	143,801	143,801	30
31	Accrued Taxes Payable (excluding real estate taxes)	86,626	86,626	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	33,575	33,575	33
34	Deferred Compensation	342,721	342,721	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued (See Detail)	220,482	220,482	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,599,866	\$ 1,599,866	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	53,196	53,196	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Other LTL (See Detail)	366,968	366,968	43
44			0	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 420,164	\$ 420,164	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,020,030	\$ 2,020,030	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,440,744	\$ 1,440,744	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,460,774	\$ 3,460,774	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Accolade Healthcare of the Heartland LLC
12/31/2020
Balance Sheet Detail

	Operating	After Consolidation
Line 9		
ACCRUED REVENUE	268,471	268,471
Employee Advances	6,591	6,591
DUE TO/FROM PAXTON	201,657	201,657
DUE TO/FROM FROM PONTIAC	175,206	175,206
DUE TO/FROM FROM PSL	161,181	161,181
DUE TO/FROM FROM MGMT CO	673,790	673,790
DUE TO/FROM FROM DANVILLE	31,162	31,162
Total	1,518,058	1,518,058
Line 23		
LOAN ACQUISITION COSTS	49,366	49,366
MCO CONTRACTS COSTS	27,800	27,800
ACCUM.AMORT LOAN ACQ COSTS	(26,209)	(26,209)
ACCUM.AMORT OF MCO CONTRACTS	(24,325)	(24,325)
OPTION DEPOSIT	344,000	344,000
CAPEX RESERVE	49,929	49,929
Total	420,561	420,561
Line 36		
Due to Affiliate	(220,482)	(220,482)
Total	220,482	220,482
Line 43		
Officer Debt - Start Up	(300,000)	(300,000)
Option Deposit liability	(40,000)	(40,000)
Deferred Rent	(26,968)	(26,968)
Total	(366,968)	(366,968)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (390,898)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (390,898)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,831,642	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)	\$ 1,831,642	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)	\$ 1,440,744	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Accolade HC Paxton on Pells

0055004

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.

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,824,256	1
2	Discounts and Allowances for all Levels	(1,987,051)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,837,205	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	281,057	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 281,057	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	2,989	13
14	Non-Patient Meals	44	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	315	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,348	23
	D. Non-Operating Revenue		
24	Contributions	1,929	24
25	Interest and Other Investment Income***	78	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,007	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	839	28
28a	PHE COVID	1,488,255	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,489,094	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,612,711	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,247,950	31
32	Health Care	2,996,209	32
33	General Administration	1,924,250	33
	B. Capital Expense		
34	Ownership	732,687	34
	C. Ancillary Expense		
35	Special Cost Centers	631,551	35
36	Provider Participation Fee	248,422	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,781,069	40
41	Income before Income Taxes (line 30 minus line 40)**	1,831,642	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,831,642	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,780,988	44
45	Private Pay - Net Inpatient Revenue	904,904	45
46	Medicare - Net Inpatient Revenue	1,350,874	46
47	Other-(specify) <u>Insurance</u>	(11,768)	47
48	Other-(specify) <u>Hospice</u>	812,207	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,837,205	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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,793	2,174	\$ 105,557	\$ 48.57	1
2	Assistant Director of Nursing	1,542	1,696	60,676	35.78	2
3	Registered Nurses	10,784	11,611	407,097	35.06	3
4	Licensed Practical Nurses	25,448	27,878	815,707	29.26	4
5	CNAs & Orderlies	58,479	61,940	949,288	15.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,999	2,099	38,335	18.26	9
10	Activity Assistants	5,119	5,523	72,988	13.21	10
11	Social Service Workers	3,947	4,240	100,649	23.74	11
12	Dietician					12
13	Food Service Supervisor	3,858	4,117	79,511	19.31	13
14	Head Cook	6,658	7,007	86,447	12.34	14
15	Cook Helpers/Assistants	16,973	17,827	187,461	10.52	15
16	Dishwashers					16
17	Maintenance Workers	3,651	3,858	77,137	20.00	17
18	Housekeepers	17,158	18,222	223,609	12.27	18
19	Laundry	1,969	2,118	49,577	23.41	19
20	Administrator	1,922	2,014	112,515	55.88	20
21	Assistant Administrator	585	606	14,062	23.20	21
22	Other Administrative	10,443	11,289	298,168	26.41	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	1,953	2,039	30,376	14.90	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	2,073	2,204	36,155	16.40	33
34	TOTAL (lines 1 - 33)	176,354	188,460	\$ 3,745,315 *	\$ 19.87	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		57,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	221	13,000	L10, C3	38
39	Pharmacist Consultant		18,715	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	56	3,693	L11, C3	44
45	Social Service Consultant	48	3,168	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	325	\$ 95,576		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	109	\$ 6,393	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	766	24,506	L10, C3	52
53	TOTAL (lines 50 - 52)	875	\$ 30,899		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES								
A. Administrative Salaries		Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount		Description	Amount
Patel, Neki V. / Young, Jason C.	Admin	0	\$ 111,061	Workers' Compensation Insurance	\$ 41,973		IDPH License Fee	\$
Moser, Caryn L.	Asst. Admin	0	13,656	Unemployment Compensation Insurance	49,931		Advertising: Employee Recruitment	8,920
				FICA Taxes	265,588		Health Care Worker Background Check	
				Employee Health Insurance	161,112		(Indicate # of checks performed)	
				Employee Meals	13,897		Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*				
				Safe Harbor	6,466			
				Less Marketing Benefits Adj	(9,997)			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 124,717					
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	()
			\$				Non-allowable advertising	()
Compliance Consultant			9,000				Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 9,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 528,970	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
ProPayHR	Payroll Processing		\$ 22,015			\$	Out-of-State Travel	\$
Platinum Billing Solutions	Billing		86,240					
Various MCO Amort (See Detail)	Payor Contracts		22,940					
STL Bookkeeping	Bookeeping		443				In-State Travel	
Global Tech Solutions	IT Services		20,242					
RubinBrown LLP	Accounting		21,875					
Accolade Management	Management Fees		406,400					
Various (See Detail)	Legal		16,767				Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 596,922	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)							TOTAL	\$

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

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?
If YES, give association name and amount. No

(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. \$ 64,427 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. \$ 248,422
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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. \$ 44

(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?

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.

SEE ACCOUNTANTS' PREPARATION REPORT