

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 N/A

	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>37</u>	Skilled (SNF)	<u>37</u>	<u>13,505</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>60</u>	Intermediate (ICF)	<u>60</u>	<u>21,900</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>35,405</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>3,475</u>		<u>3,558</u>	<u>7,033</u>	8	
9	SNF/PED					9	
10	ICF	<u>13,902</u>	<u>4,149</u>	<u>874</u>	<u>18,925</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>17,377</u>	<u>4,149</u>	<u>4,432</u>	<u>25,958</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.32%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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 10/15/2014

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/15/2014 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 37 and days of care provided 3,558

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number

Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	202,205	14,671	7,512	224,388		224,388		224,388		1
2	Food Purchase		122,045		122,045		122,045	(112)	121,933		2
3	Housekeeping	114,483	24,695		139,178		139,178		139,178		3
4	Laundry	38,566	16,626		55,192		55,192		55,192		4
5	Heat and Other Utilities			121,716	121,716		121,716	(16,649)	105,067		5
6	Maintenance	38,886	37,405	36,482	112,773		112,773	7,023	119,796		6
7	Other (specify):*										7
8	TOTAL General Services	394,140	215,442	165,710	775,292		775,292	(9,738)	765,554		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,457,701	12,596	7,021	1,477,318		1,477,318	36,361	1,513,679		10
10a	Therapy	13,320	582	3,850	17,752		17,752		17,752		10a
11	Activities	161,368	5,177		166,545		166,545		166,545		11
12	Social Services	39,806		1,436	41,242		41,242		41,242		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							5,545	5,545		15
16	TOTAL Health Care and Programs	1,672,195	18,355	19,507	1,710,057		1,710,057	41,906	1,751,963		16
	C. General Administration										
17	Administrative	80,727			80,727		80,727	43,722	124,449		17
18	Directors Fees										18
19	Professional Services			305,991	305,991		305,991	(249,652)	56,339		19
20	Dues, Fees, Subscriptions & Promotions			46,378	46,378		46,378	(13,187)	33,191		20
21	Clerical & General Office Expenses	83,539	5,698	108,392	197,629		197,629	44,581	242,210		21
22	Employee Benefits & Payroll Taxes			325,413	325,413		325,413		325,413		22
23	Inservice Training & Education										23
24	Travel and Seminar			607	607		607	229	836		24
25	Other Admin. Staff Transportation			16,194	16,194		16,194	8,416	24,610		25
26	Insurance-Prop.Liab.Malpractice			46,841	46,841		46,841	998	47,839		26
27	Other (specify):*							22,364	22,364		27
28	TOTAL General Administration	164,266	5,698	849,816	1,019,780		1,019,780	(142,528)	877,252		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,230,601	239,495	1,035,033	3,505,129		3,505,129	(110,361)	3,394,768		29

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

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

Facility Name & ID Number Pontiac Healthcare And Rehab #0053264 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			15,088	15,088		15,088	160,897	175,985			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,180	53,180		53,180	162,412	215,592			32
33	Real Estate Taxes			72,190	72,190		72,190		72,190			33
34	Rent-Facility & Grounds			534,025	534,025		534,025	(529,340)	4,685			34
35	Rent-Equipment & Vehicles			17,960	17,960		17,960	(1,146)	16,814			35
36	Other (specify):*											36
37	TOTAL Ownership			692,443	692,443		692,443	(207,177)	485,266			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		208,663	595,606	804,269		804,269		804,269			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			189,221	189,221		189,221		189,221			42
43	Other (specify):*	46,302			46,302		46,302	(46,302)	0			43
44	TOTAL Special Cost Centers	46,302	208,663	784,827	1,039,792		1,039,792	(46,302)	993,490			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,276,903	448,158	2,512,303	5,237,364		5,237,364	(363,839)	4,873,525			45

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

Pontiac Healthcare And Rehab

ID# 0053264

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscallaneous Income	\$ (962)	21	1
2	Marketing Expenses	(46,302)	43	2
3	Bank Charges	(18,313)	21	3
4	Theft & Damage Loss	(1,885)	21	4
5	Additional R&M	11,267	06	5
6	Capitalized R&M	(4,250)	06	6
7	Non Allowable Auto Lease	(5,341)	35	7
8	Non Allowable Legal Fees	(4,495)	19	8
9	Bldg Co - Bank Charges	(74)	21	9
10	Bldg Co - Amortization	(12,586)	36	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
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	(82,940)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(195)		83									(112)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(17,485)		836									(16,649)	5
6	Maintenance	7,017		6									7,023	6
7	Other (specify):*													7
8	TOTAL General Services	(10,663)		925									(9,738)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			36,361									36,361	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,545									5,545	15
16	TOTAL Health Care and Programs			41,906									41,906	16
	C. General Administration													
17	Administrative			43,722									43,722	17
18	Directors Fees													18
19	Professional Services	(4,495)		(245,157)									(249,652)	19
20	Fees, Subscriptions & Promotions	(16,292)		3,105									(13,187)	20
21	Clerical & General Office Expenses	(52,663)	74	97,170									44,581	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			229									229	24
25	Other Admin. Staff Transportation			8,416									8,416	25
26	Insurance-Prop.Liab.Malpractice			998									998	26
27	Other (specify):*			22,364									22,364	27
28	TOTAL General Administration	(73,450)	74	(69,152)									(142,528)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(84,113)	74	(26,322)									(110,361)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	(486,878)	646,172	1,603									160,897	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3)	162,396	19									162,412	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(534,025)	4,685									(529,340)	34
35	Rent-Equipment & Vehicles	(5,341)		4,195									(1,146)	35
36	Other (specify):*	(12,586)	12,586											36
37	TOTAL Ownership	(504,808)	287,129	10,502									(207,177)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(46,302)											(46,302)	43
44	TOTAL Special Cost Centers	(46,302)											(46,302)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(635,222)	287,203	(15,820)									(363,839)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Pg 6-Supplemental		See Pg 6-Supplemental		See Pg 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 534,025	Pontiac Health Care Property	100.00%	\$	(534,025)	1
2	V	21 Bank Services Charges		Pontiac Health Care Property	100.00%	74	74	2
3	V	30 Depreciation		Pontiac Health Care Property	100.00%	646,172	646,172	3
4	V	36 Amortization		Pontiac Health Care Property	100.00%	12,586	12,586	4
5	V	32 Interest		Pontiac Health Care Property	100.00%	162,396	162,396	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		\$ 534,025			\$ 821,228	\$ * 287,203	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$		15
16	V	<u>2</u> <u>FOOD</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	83	83	16
17	V	<u>5</u> <u>UTILITIES</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	836	836	17
18	V	<u>6</u> <u>REPAIRS AND MAINTENANCE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	6	6	18
19	V	<u>10</u> <u>NURSING</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	36,361	36,361	19
20	V	<u>15</u> <u>EMP. BEN. HEALTHCARE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	5,545	5,545	20
21	V	<u>17</u> <u>ADMINISTRATIVE SALARIES</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	17,697	17,697	21
22	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	8,338	8,338	22
23	V	<u>20</u> <u>DUES, FEES, SUBSCRIPTIONS</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	3,105	3,105	23
24	V	<u>21</u> <u>SALARIES - CLERICAL</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	87,650	87,650	24
25	V	<u>21</u> <u>OFFICE EXPENSES</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	9,520	9,520	25
26	V	<u>24</u> <u>SEMINAR EXPENSE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	229	229	26
27	V	<u>25</u> <u>AUTO & TRAVEL EXPENSE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	8,416	8,416	27
28	V	<u>26</u> <u>INSURANCE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	998	998	28
29	V	<u>27</u> <u>EMP. BEN. GEN. ADMIN.</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	17,123	17,123	29
30	V	<u>30</u> <u>DEPRECIATION</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	1,603	1,603	30
31	V	<u>32</u> <u>INTEREST</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	19	19	31
32	V	<u>34</u> <u>RENT</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	4,685	4,685	32
33	V	<u>35</u> <u>EQUIPMENT RENTAL</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	605	605	33
34	V	<u>35</u> <u>AUTO LEASE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	3,590	3,590	34
35	V							35
36	V	<u>17</u> <u>ADMIN COMP - B. ALTER</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	26,025	26,025	36
37	V	<u>27</u> <u>EMP. BEN. - B. ALTER</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	5,241	5,241	37
38	V	<u>19</u> <u>HOME OFFICE EXPENSE</u>	253,495	<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%		(253,495)	38
39	Total		\$ 253,495			\$ 237,675	\$ * (15,820)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Pontiac Healthcare And Rehab

#

0053264

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	Bradley Alter	Owner	Administration	60.00%	See Attached	6.51	13.02%	Alloc. Salary	\$ 26,025	17-7	1	
2	Daniel Alter	Relative	Clerical	0	See Attached	4.55	13.00%	Alloc. Salary	4,716	21-7	2	
3	Zev Geller	Relative	Clerical	0	See Attached	1.14	13.03%	Alloc. Salary	1,350	21-7	3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 32,091		13	

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

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

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 CERTIFIED HEALTH MANAGEMENT
 Street Address 3856 W. OAKTON
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-4700
 Fax Number (847) 674-4733

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1					\$	\$		\$	1	
2	2	FOOD	PATIENT DAYS	199,483	6	639	25,958	83	2	
3	5	UTILITIES	PATIENT DAYS	199,483	6	6,424	25,958	836	3	
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	199,483	6	43	25,958	6	4	
5	10	NURSING	PATIENT DAYS	199,483	6	279,428	279,428	36,361	5	
6	15	EMP. BEN. HEALTHCARE	PATIENT DAYS	199,483	6	42,613	25,958	5,545	6	
7	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	199,483	6	136,000	136,000	17,697	7	
8	19	PROFESSIONAL FEES	PATIENT DAYS	199,483	6	64,080	25,958	8,338	8	
9	20	DUES, FEES, SUBSCRIPTIONS	PATIENT DAYS	199,483	6	23,865	25,958	3,105	9	
10	21	SALARIES - CLERICAL	PATIENT DAYS	199,483	6	673,576	673,576	87,650	10	
11	21	OFFICE EXPENSES	PATIENT DAYS	199,483	6	73,160	25,958	9,520	11	
12	24	SEMINAR EXPENSE	PATIENT DAYS	199,483	6	1,756	25,958	229	12	
13	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	199,483	6	64,679	25,958	8,416	13	
14	26	INSURANCE	PATIENT DAYS	199,483	6	7,669	25,958	998	14	
15	27	EMP. BEN. GEN. ADMIN.	PATIENT DAYS	199,483	6	131,588	25,958	17,123	15	
16	30	DEPRECIATION	PATIENT DAYS	199,483	6	12,317	25,958	1,603	16	
17	32	INTEREST	PATIENT DAYS	199,483	6	148	25,958	19	17	
18	34	RENT	PATIENT DAYS	199,483	6	36,000	25,958	4,685	18	
19	35	EQUIPMENT RENTAL	PATIENT DAYS	199,483	6	4,652	25,958	605	19	
20	35	AUTO LEASE	PATIENT DAYS	199,483	6	27,586	25,958	3,590	20	
21									21	
22	17	ADMIN COMP - B. ALTER	AVERAGE HOURS WORKE	50	6	200,000	200,000	6.51	26,025	22
23	27	EMP. BEN. - B. ALTER	AVERAGE HOURS WORKE	50	6	40,273		6.51	5,241	23
24									24	
25	TOTALS					\$ 1,826,494	\$ 1,289,004	\$ 237,675	25	

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number **Pontiac Healthcare And Rehab**

0053264 Report Period Beginning: **01/01/15** Ending: **12/31/15**

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	Eric Rothner	X		Loan			\$	\$ 4,640,071		\$ 162,396	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	Bank Leumi		X	Line of Credit				1,126,575		52,663	6									
7	Insurance Financing		X							517	7									
8											8									
9	TOTAL Facility Related						\$	\$ 5,766,646		\$ 215,576	9									
B. Non-Facility Related*																				
10	Interest Income		X							(3)	10									
11	Allocated from Certified Health Management									19	11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ 16	14									
15	TOTALS (line 9+line14)						\$	\$ 5,766,646		\$ 215,592	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

Facility Name & ID Number

Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term										7									
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital										14									
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related										20									

* 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' COMPILATION REPORT

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

(See instructions.)

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 2014 report.		\$	56,250		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.)		\$	63,271		2
3. Under or (over) accrual (line 2 minus line 1).		\$	7,021		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	65,169		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.		\$	72,190		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>45,827</u>	8	FOR BHF USE ONLY	
	2011	<u>46,309</u>	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
	2012	<u>62,385</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	<u>62,967</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2014	<u>63,271</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2015 Accrual = \$63,271 x 1.03 = \$65,169					
Beginning Accrual Adjusted					

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.

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending:

12/31/15

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. (c) Rent from Completely Unrelated Organization.

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

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

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an unlabeled column. Row 1: Facility, 226,543, 1. Row 2: 2, 2. Row 3: TOTALS, 226,543, 3.

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	97		2014	1962	\$ 3,967,022	\$ 646,172	35	\$ 113,343	\$ (532,829)	\$ 226,687	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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
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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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			15,708	996	785	(211)	11,907	68	
69				15,088		(15,088)		69	
70			\$ 3,982,730	\$ 662,256		\$ 114,128	\$ (548,128)	\$ 238,594	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 3,982,730	\$ 662,256		\$ 114,128	\$ (548,128)	\$ 238,594	1
2	Installation Of Camera Monitor System	2015	18,200		20	188	188	188	2
3	Phone System	2015	5,025		20	754	754	754	3
4	Boiler Repair	2015	3,942		20	49	49	49	4
5	Boiler Repair	2015	11,828		20	148	148	148	5
6	Generator Repair	2015	2,639		20	22	22	22	6
7	Roof Repairs Along Gutter Line	2015	4,250		20	213	213	213	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,028,614	\$ 662,256		\$ 115,501	\$ (546,755)	\$ 239,967	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,028,614	\$ 662,256		\$ 115,501	\$ (546,755)	\$ 239,967	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
31								31
32								32
33								33
34		\$ 4,028,614	\$ 662,256		\$ 115,501	\$ (546,755)	\$ 239,967	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,028,614	\$ 662,256		\$ 115,501	\$ (546,755)	\$ 239,967	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
31								31
32								32
33								33
34		\$ 4,028,614	\$ 662,256		\$ 115,501	\$ (546,755)	\$ 239,967	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,028,614	\$ 662,256		\$ 115,501	\$ (546,755)	\$ 239,967	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
31								31
32								32
33								33
34		\$ 4,028,614	\$ 662,256		\$ 115,501	\$ (546,755)	\$ 239,967	34

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

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	
1	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

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	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Certified Health Management	1997	12,261	307	20	613	306	11,648	9
10	Allocated from Certified Health Management	2014	3,447	689	20	172	(517)	259	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,708	\$ 996		\$ 785	\$ (211)	\$ 11,907	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 15,708	\$ 996		\$ 785	\$ (211)	\$ 11,907	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 15,708	\$ 996		\$ 785	\$ (211)	\$ 11,907	34

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

Facility Name & ID Number Pontiac Healthcare And Rehab

0053264

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 499,338	\$ 590	\$ 50,722	\$ 50,132	10	\$ 102,010	71
72	Current Year Purchases	56,861	17	9,734	9,717	10	9,734	72
73	Fully Depreciated Assets	24,725		28	28	10	24,691	73
74								74
75	TOTALS	\$ 580,924	\$ 607	\$ 60,484	\$ 59,877		\$ 136,435	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$			\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$			\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,836,081	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 662,863	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 175,985	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (486,878)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 376,402	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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:			\$			3
4	Additions						4
5	<u>Allocated from Certified Health Management</u>			<u>4,685</u>			5
6							6
7	TOTAL			\$ 4,685			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 _____.

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: \$ 5,763 Description: See Attached Schedule

(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	<u>Facility</u>	<u>2015 Ford Challenger</u>	\$ <u>899.00</u>	\$ <u>7,461</u>	17
18	<u>Allocated from Certified Health Management</u>			<u>3,590</u>	18
19					19
20					20
21	TOTAL		\$ 899.00	\$ 11,051	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2016 \$ _____

13. /2017 \$ _____

14. /2018 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Staff		Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	233,553	\$			\$	233,553	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				77,680					77,680	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs				284,373					284,373	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	39 - 02	# of prescripts						109,893			109,893	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify):												12
13	Other (specify): <u>See Supplemental</u>								98,770			98,770	13
14	TOTAL			\$		\$	595,606	\$	208,663		\$	804,269	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.

Facility Name & ID Number **Pontiac Healthcare And Rehab**

0053264

Report Period Beginning: **01/01/15**

Ending: **12/31/15**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/15** (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	\$ 37,221	\$ 265,886	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,899,942	1,914,071	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,209	61,209	6
7	Other Prepaid Expenses	12,353	12,353	7
8	Accounts Receivable (owners or related parties)	850	850	8
9	Other(specify):	88,959	88,959	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,100,534	\$ 2,343,328	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		226,543	13
14	Buildings, at Historical Cost		3,967,022	14
15	Leasehold Improvements, at Historical Cost	32,022	32,022	15
16	Equipment, at Historical Cost	82,564	570,890	16
17	Accumulated Depreciation (book methods)	(15,171)	(69,640)	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):	23,000	765,558	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 122,415	\$ 5,492,395	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,222,949	\$ 7,835,723	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 247,047	\$ 747,047	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,126,575	1,126,575	29
30	Accrued Salaries Payable	157,890	157,890	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,401	81,517	31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,169	65,169	32
33	Accrued Interest Payable	1,881	1,881	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	108,307	496,307	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,722,270	\$ 2,676,386	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		4,640,071	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)	\$	\$ 4,640,071	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,722,270	\$ 7,316,457	46
47	TOTAL EQUITY(page 18, line 24)	\$ 500,679	\$ 519,266	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,222,949	\$ 7,835,723	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 315,994	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 315,994	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	184,685	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)	\$ 184,685	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 500,679	24 *

* This must agree with page 17, line 47.

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

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

1		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,133,732	1
2	Discounts and Allowances for all Levels	936,170	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,069,902	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	346,032	6
7	Oxygen	151	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 346,183	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	2,968	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	57	19
20	Radiology and X-Ray	119	20
21	Other Medical Services	1,855	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,999	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	962	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 962	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,422,049	30

2		3	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	775,292	31
32	Health Care	1,710,057	32
33	General Administration	1,019,780	33
B. Capital Expense			
34	Ownership	692,443	34
C. Ancillary Expense			
35	Special Cost Centers	850,571	35
36	Provider Participation Fee	189,221	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,237,364	40
41	Income before Income Taxes (line 30 minus line 40)**	184,685	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 184,685	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,410,946	44
45	Private Pay - Net Inpatient Revenue	772,776	45
46	Medicare - Net Inpatient Revenue	1,612,927	46
47	Other-(specify) Hospice, Managed Care	273,253	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,069,902	49

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

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

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

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

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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	1,777	1,783	\$ 80,926	\$ 45.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,199	11,324	289,211	25.54	3
4	Licensed Practical Nurses	15,463	15,682	403,168	25.71	4
5	CNAs & Orderlies	43,896	44,385	666,667	15.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,259	1,313	13,320	10.14	8
9	Activity Director	1,530	1,576	40,150	25.48	9
10	Activity Assistants	11,777	12,268	121,218	9.88	10
11	Social Service Workers	1,630	1,648	30,885	18.74	11
12	Dietician					12
13	Food Service Supervisor	1,654	1,696	44,452	26.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,752	14,796	157,753	10.66	15
16	Dishwashers					16
17	Maintenance Workers	1,795	1,810	38,886	21.48	17
18	Housekeepers	12,566	12,617	114,483	9.07	18
19	Laundry	3,989	4,108	38,566	9.39	19
20	Administrator	1,645	1,648	80,727	48.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,438	3,555	63,881	17.97	23
24	Clerical	1,430	1,479	19,658	13.29	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	1,543	1,551	17,729	11.43	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,511	2,612	55,222	21.15	33
34	TOTAL (lines 1 - 33)	133,854	135,851	\$ 2,276,902 *	\$ 16.76	34

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

** See instructions.

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	150	\$ 7,512	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	29	1,464	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	111	5,557	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	29	1,436	12-03	45
46	Other(specify)				46
47	Rehab Consultant	Monthly	3,850	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	319	\$ 27,019		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
John Bernadyn	Administrator	0	\$ 24,923	Workers' Compensation Insurance	\$ 64,696	IDPH License Fee	\$	
Carolyn McBride	Administrator	0	55,804	Unemployment Compensation Insurance	10,316	Advertising: Employee Recruitment	16,364	
				FICA Taxes	174,183	Health Care Worker Background Check		
				Employee Health Insurance	66,674	(Indicate # of checks performed <u>91</u>)	925	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	10,041	
				Pension Plan Contribution	9,194	Licenses & Permits	2,756	
				Other Employee Benefits	350	Allocated from Certified Health Management	3,105	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 80,727					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount				Less: Public Relations Expense ()	
			\$				Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(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
FR&R/Marcum LLP	Accounting		\$ 1,500			\$	Out-of-State Travel	\$
Certified Health Management	Home Office Expense		253,495					
Peterson Healthcare Consulting	Healthcare Consulting		3,498					
E-Health Data Solutions	Data Processing		3,600				In-State Travel	
Paychex	Payroll Processing		15,929					
Personnel Planners	Unemployment Consultant		1,340					
Wescom Solutions	Data Processing		21,202					
See Attached	Legal Fees		5,427				Seminar Expense	607
							Allocated from Certified Health Management	229
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 305,992				TOTAL \$ 836	

* Attach copy of IMRF notifications

**See instructions.

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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. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 189,221
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. \$ None Has any meal income been offset against related costs? None Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.