FOR BHF USE

LL1

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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0052449

Facility Name: PARK POINTE HLTHCARE & REHAB

Address: 1223 EDGEWATER DRIVE (Number) MORRIS (City) 60450 (Zip Code)

County: GRUNDY

Telephone Number: (815) 416-6500 **Fax #** (815) 416-6201

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2013

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: SUZANNE DAY **Telephone Number:** (815) 416-6500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) SUZANNE DAY
(Title) ADMINISTRATOR

Paid Preparer
(Signed) (Date)
(Print Name and Title) BART MCCURLEY, CPA
(Firm Name & Address) CARR, RIGGS & INGRAM, LLC, 1601 2ND AVE E, ONEONTA, AL 35121
(Telephone) (205) 625-3472 Fax # (205) 274-0182

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

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	142	Skilled (SNF)	142	51,972	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	142	TOTALS	142	51,972	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,321	16,447	7,856	41,624	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,321	16,447	7,856	41,624	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.09%

D. How many bed-hold days during this year were paid by the Department?
0 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 11/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 142 and days of care provided 7,188

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	392,183	28,028	(670)	419,541		419,541		419,541			1
2	Food Purchase		296,150		296,150		296,150	(5)	296,145			2
3	Housekeeping	146,934	29,337		176,271		176,271		176,271			3
4	Laundry	103,045	20,048		123,093		123,093		123,093			4
5	Heat and Other Utilities			162,459	162,459		162,459		162,459			5
6	Maintenance	86,365	2,937	68,174	157,476		157,476		157,476			6
7	Other (specify):*											7
8	TOTAL General Services	728,527	376,500	229,963	1,334,990		1,334,990	(5)	1,334,985			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,528,201	107,403	80,545	2,716,149		2,716,149		2,716,149			10
10a	Therapy	503,182	260,546		763,728		763,728		763,728			10a
11	Activities	89,507	1,664		91,171		91,171		91,171			11
12	Social Services	52,479		2,731	55,210		55,210		55,210			12
13	CNA Training											13
14	Program Transportation		1,778		1,778		1,778		1,778			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,173,369	371,391	101,276	3,646,036		3,646,036		3,646,036			16
	C. General Administration											
17	Administrative	423,593	51	4,399	428,043		428,043	(1,243)	426,800			17
18	Directors Fees											18
19	Professional Services			684,279	684,279		684,279	(261,025)	423,254			19
20	Dues, Fees, Subscriptions & Promotions			1,906	1,906		1,906	(1,906)				20
21	Clerical & General Office Expenses		18,793	149,546	168,339		168,339	(22,315)	146,024			21
22	Employee Benefits & Payroll Taxes			733,355	733,355		733,355		733,355			22
23	Inservice Training & Education			2,011	2,011		2,011		2,011			23
24	Travel and Seminar			57	57		57		57			24
25	Other Admin. Staff Transportation			9,169	9,169		9,169	(9,169)				25
26	Insurance-Prop.Liab.Malpractice			97,879	97,879		97,879		97,879			26
27	Other (specify):*											27
28	TOTAL General Administration	423,593	18,844	1,682,601	2,125,038		2,125,038	(295,658)	1,829,380			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,325,489	766,735	2,013,840	7,106,064		7,106,064	(295,663)	6,810,401			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 PARK POINTE HLTHCARE & REHAB #0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest			106,342	106,342		106,342		106,342			32
33	Real Estate Taxes			106,293	106,293		106,293	2,113	108,406			33
34	Rent-Facility & Grounds			2,110,903	2,110,903		2,110,903		2,110,903			34
35	Rent-Equipment & Vehicles			10,737	10,737		10,737		10,737			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,334,275	2,334,275		2,334,275	2,113	2,336,388			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			49,711	49,711		49,711		49,711			39
40	Barber and Beauty Shops	2,960			2,960		2,960		2,960			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			261,786	261,786		261,786		261,786			42
43	Other (specify):* **Presc Drugs**			216,014	216,014		216,014		216,014			43
44	**TOTAL Special Cost Centers**	2,960		527,511	530,471		530,471		530,471			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,328,449	766,735	4,875,626	9,970,810		9,970,810	(293,550)	9,677,260			45

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

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	(5)	2		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				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)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(22,315)	21		18
19	Entertainment	(1,243)	17		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,906)	20		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)**	$ (25,469)		$	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)	(253,546)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (253,546)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (279,015)		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

PARK POINTE HLTHCARE & REHAB

ID# 0052449

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VEHICLE RENT	$ (9,169)	25	1
2	UNALLOWABLE LEGAL FEES	(7,479)	19	2
3	ADJUST PROPERTY TAXES PD BY LESSOR	2,113	33	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				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**	(14,535)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5)	0	0	0	0	0	0	0	0	0	0	(5)	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5)	0	0	0	0	0	0	0	0	0	0	(5)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(1,243)	0	0	0	0	0	0	0	0	0	0	(1,243)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,479)	(253,546)	0	0	0	0	0	0	0	0	0	(261,025)	19
20	Fees, Subscriptions & Promotions	(1,906)	0	0	0	0	0	0	0	0	0	0	(1,906)	20
21	Clerical & General Office Expenses	(22,315)	0	0	0	0	0	0	0	0	0	0	(22,315)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(9,169)	0	0	0	0	0	0	0	0	0	0	(9,169)	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**	(42,112)	(253,546)	0	0	0	0	0	0	0	0	0	(295,658)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(42,117)	(253,546)	0	0	0	0	0	0	0	0	0	(295,663)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	2,113	0	0	0	0	0	0	0	0	0	0	2,113	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,113	0	0	0	0	0	0	0	0	0	0	2,113	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(40,004)	(253,546)	0	0	0	0	0	0	0	0	0	(293,550)	45

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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
THE ROBERT WESTERKAMP TRUST	95			HORIZON HEALTHCARE; GLEN ELLYN		CONSULTING
ROBERT WESTERKAMP	5					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	ACCOUNTING	$ 30,000	HORIZON HEALTHCARE, LLC	0.00%	$ 15,764	$ (14,236)	1
2	V	19	CONSULTING SERVICES	504,312	HORIZON HEALTHCARE, LLC	0.00%	265,002	(239,310)	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			$ 534,312			$ 280,766	$ * (253,546)	14

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

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AARON WESTERKAMP	IT MANAGER	IT SERVICES	0.00	0	40	100.00	SALARY	$ 50,000	17	1
2	ROBERT WESTERKAMP	LLC MANAGER	LLC MANAGER	5.00	0	20	50.00	PMT OF SVC	75,000	21	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 125,000		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 PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 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						$	$		$	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 PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Merchants Bank of Indiana		X	Working Capital	None			1,966,615		5.0000	106,342	6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,966,615			$ 106,342	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 1,966,615			$ 106,342	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.)

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	108,406	2
3. Under or (over) accrual (line 2 minus line 1).	$	108,406	3
4. Real Estate Tax accrual used for 2016 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.	$	108,406	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013	67,844	10
2014	101,885	11
2015	108,406	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PARK POINTE HLTHCARE & REHAB COUNTY GRUNDY

FACILITY IDPH LICENSE NUMBER 0052449

CONTACT PERSON REGARDING THIS REPORT SUZANNE DAY

TELEPHONE (815) 416-6500 FAX #: (815) 416-6201

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-05-203-007	Nursing Home Land, Building	$ 108,405.50	$ 108,405.50
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 108,405.50	$ 108,405.50

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,490 B. General Construction Type: Exterior Concrete/Brick Frame Concrete/Steel Number of Stories 2

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

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

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

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

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

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

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											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

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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)		$	$		$	$	$	70

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

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$	$	$		$	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)	$	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	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.

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FNR MORRIS, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	2010	142	11/1/2013	$ 2,110,903	10	10	3
4	Additions							4
5								5
6								6
7	TOTAL		142		$ 2,110,903 **			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 0 .

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

10. Effective dates of current rental agreement:
Beginning 11/1/2013
Ending 10/31/2023

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2017	$ 1500000 MINIMUM
13.	12/31/2018	$ 1500000 MINIMUM
14.	12/31/2019	$ 1500000 MINIMUM

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

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

16. Rental Amount for movable equipment: $ ALL INCLUSIVE Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-1	2996 hrs	$ 184,011	523	$ 108,409	$ 20	3,519	$ 292,440	1
2	Licensed Speech and Language Development Therapist	10A-1	1552 hrs	65,173	295	60,303		1,847	125,476	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-1	3544 hrs	189,786	498	91,792	20	4,042	281,598	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	43-3	# of prescrpts				216,014		216,014	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ 438,970	1,316	$ 260,504	$ 216,054	9,408	$ 915,528	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 PARK POINTE HLTHCARE & REHAB **#** 0052449 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ (204,586)	$	1
2	Cash-Patient Deposits	15,818		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,550,049		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	81,933		6
7	Other Prepaid Expenses	50,174		7
8	Accounts Receivable (owners or related parties)	705,753		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,199,141	$	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	37,795		15
16	Equipment, at Historical Cost	83,809		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges	66,929		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Loan & Acquisition c	2,056,841		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,245,374	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,444,515	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,419,605	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,010		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	323,928		30
31	Accrued Taxes Payable (excluding real estate taxes)	82,891		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued management fees	5,140		36
37	Due to Medicaid	33,909		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,869,483	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,966,615		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to related party	403,778		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,370,393	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,239,876	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 204,639	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,444,515	$	48

***(See instructions.)**

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 93,418	1
2	Restatements (describe):		2
3	**PRIOR YEAR BILLING ADJUSTMENTS**	(4,220)	3
4	**ROUNDING**	6	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 89,204	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	115,435	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)**	$ 115,435	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)**	$ 204,639	24 *

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

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,866,501	1
2	Discounts and Allowances for all Levels	331,638	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,198,139	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,746,287	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,746,287	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	5	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	126,210	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,605	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 141,820	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,086,246	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,334,990	31
32	Health Care	3,646,036	32
33	General Administration	2,125,038	33
	B. Capital Expense		
34	Ownership	2,334,275	34
	C. Ancillary Expense		
35	Special Cost Centers	268,686	35
36	Provider Participation Fee	261,786	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,970,811	40
41	**Income before Income Taxes (line 30 minus line 40)****	115,435	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 115,435	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,464,467	44
45	Private Pay - Net Inpatient Revenue	2,900,524	45
46	Medicare - Net Inpatient Revenue	2,273,230	46
47	Other-(specify) Hospice	562,957	47
48	Other-(specify) Insurance	(3,039)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,198,139	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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.**

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,130	2,130	$ 69,782	$ 32.76	1
2	Assistant Director of Nursing	1,983	1,983	60,559	30.54	2
3	Registered Nurses	20,419	21,521	566,817	26.34	3
4	Licensed Practical Nurses	17,818	18,751	413,462	22.05	4
5	CNAs & Orderlies	96,499	99,546	1,357,036	13.63	5
6	CNA Trainees					6
7	Licensed Therapist	8,110	8,990	472,906	52.60	7
8	Rehab/Therapy Aides	3,666	3,978	98,147	24.67	8
9	Activity Director	1,975	2,111	26,492	12.55	9
10	Activity Assistants	6,216	6,464	63,693	9.85	10
11	Social Service Workers	3,204	3,556	52,479	14.76	11
12	Dietician	111	119	4,498	37.80	12
13	Food Service Supervisor	2,080	2,080	48,027	23.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,971	32,704	339,183	10.37	15
16	Dishwashers					16
17	Maintenance Workers	5,794	6,074	86,365	14.22	17
18	Housekeepers	12,830	13,665	146,934	10.75	18
19	Laundry	9,738	10,317	103,045	9.99	19
20	Administrator	2,080	2,240	114,709	51.21	20
21	Assistant Administrator					21
22	Other Administrative	7,950	8,327	147,823	17.75	22
23	Office Manager					23
24	Clerical	8,695	9,262	161,061	17.39	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	5,283	5,612	60,545	10.79	31
32	Other Health Care(specify)					32
33	Other(specify) Beauty & Barber	195	195	2,960	15.18	33
34	TOTAL (lines 1 - 33)	247,747	259,625	$ 4,396,523 *	$ 16.93	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		18,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		17,124	10-3	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		2,731	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 37,855		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		2,811	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 2,811		53

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
See separate schedule			423,593
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 423,593

B. Administrative - Other

Description	Amount
Meals & entertainment	$ 1,243
Taxes & licenses	3,022
Minor equipment	134
TOTAL (agree to Schedule V, line 17, col. 3)	$ 4,399
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network	Mcare Consulting	$ 3,120
Gibson Court Reporting	Consulting	484
Momkus Mccluskey	Legal Fees	68,148
O'Neil, Parker & Williamson	Legal Fees	2,094
Vedder Price	Legal Fees	5,606
Carr, Riggs & Ingram	Accounting/Data Processing	58,515
Horizon Healthcare	Accounting Service	30,000
Michael Weisberg	Accounting	12,000
Horizon Healthcare	Consulting/Management	504,312
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 684,279

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,545
Unemployment Compensation Insurance	33,032
FICA Taxes	319,279
Employee Health Insurance	278,258
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee physicals	47
Employee relations	7,194
TOTAL (agree to Schedule V, line 22, col.8)	$ 733,355

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,906
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,906

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	57
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 57

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PARK POINTE HLTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **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 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,513** 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. **N/A**

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **NO** 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. $ **261,786**
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. $ **0** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **0**

(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? **0**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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

Park Pointe Healthcare & Rehab Center, LLC
Provider: 0052449
XIX-A - Schedule of Administrative Salaries

Name	Function	Ownership %	Amount
Suzanne Day	Administrator	0	114,709
Debra Johnson	Office Staff	0	36,058
Joan Johnson	Office Staff	0	27,160
Aaron Westerkamp	Office Staff	0	50,000
Janet Struck	Bookkeeper	0	39,520
Kimberly Gordon	Bookkeeper	0	29,199
Lynn Marie-Paul	Bookkeeper	0	23,856
Roseann Taylor	Administrative	0	60,299
Kelsey Irelan	Receptionist	0	4,275
Susan Darling	Receptionist	0	13,163
Becky Armstrong	Receptionist	0	15,265
Rebecca Foster	Receptionist	0	1,166
Leigh Haseman	Receptionist	0	1,574
Kenne Durbin	Receptionist	0	7,349
Total			423,593

Park Pointe Healthcare & Rehab Center, LLC
Provider: 0052449
XIX-A - Schedule of Legal Fees

Vendor	Amount	Allowable Amount	Description	
MOMKUS MCCLUSKEY LLC /IN: 124549	1,520.00	1,520.00	Vendor lawsuit, prior owner	
MOMKUS MCCLUSKEY LLC /IN: 160229	2,520.00	2,520.00	Vendor lawsuit, prior owner	
VEDDER PRICE PC /IN: 564079	2,156.25	0.00	Union negotiations	
MOMKUS MCCLUSKEY LLC /IN: 126038	2,736.09	2,736.09	Vendor lawsuit, prior owner	
O'NEIL, PARKER & WILLIAMSON /IN: 2014361	259.00	259.00	Vendor lawsuit, prior owner	
O'NEIL, PARKER & WILLIAMSON /IN: 2015370	816.00	816.00	Vendor lawsuit, prior owner	
MOMKUS MCCLUSKEY LLC /IN: 12692	160.00	160.00	Vendor lawsuit, prior owner	
MOMKUS MCCLUSKEY LLC /IN: 128518	8,111.29	8,111.29	Vendor lawsuit, prior owner	
MOMKUS MCCLUSKEY LLC /IN: 130637	680.00	680.00	Vendor lawsuit, prior owner	
MOMKUS MCCLUSKEY LLC /IN: 131349	7,270.00	7,270.00	Vendor lawsuit, prior owner	
GIBSON COURT REPORTING /IN: 82414	483.50	0.00	Court reporting fees	
GROVE & ASSOCIATES REPORTING /IN: 5206	694.80	0.00	Court reporting fees	
O'NEIL, PARKER & WILLIAMSON /IN: 2016124	154.00	154.00	Vendor lawsuit, prior owner	
O'NEIL, PARKER & WILLIAMSON /IN: 2016124	686.00	686.00	Vendor lawsuit, prior owner	
MOMKUS MCCLUSKEY LLC /IN: 134045	13,563.87	13,563.87	Vendor lawsuit, prior owner	
MOMKUS MCCLUSKEY LLC /IN: 134045A	4,280.00	4,280.00	Vendor lawsuit, prior owner	
ATKINSON-BAKER, INC /IN: AA08E49AA	693.95	0.00		
O'NEIL, PARKER & WILLIAMSON /IN: 201683	178.50	178.50	Vendor lawsuit, prior owner	
MOMKUS MCCLUSKEY LLC /IN: 135403	3,823.95	3,823.95	Vendor lawsuit, prior owner	
MOMKUS MCCLUSKEY LLC /IN: 136481	5,280.00	5,280.00	Vendor lawsuit, prior owner	
VEDDER PRICE PC /IN: 596114	3,450.00	0.00	Union negotiations	
MOMKUS MCCLUSKEY LLC /IN: 137290	14,670.00	14,670.00	Vendor lawsuit, prior owner	
	74,187.20	66,708.70		7,478.50