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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0052449

Facility Name: PARK POINTE HEALTHCARE & REHAB CENTER

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
			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2017 to 12/31/2017 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 EAST 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

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

Facility Name & ID Number PARK POINTE HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	142	Skilled (SNF)	142	51,830	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	51,830	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,873	16,978	7,717	38,568	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,873	16,978	7,717	38,568	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.41%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 7,570

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number PARK POINTE HEALTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	391,798	25,037	13,530	430,365		430,365		430,365			1
2	Food Purchase		296,185		296,185		296,185	(10)	296,175			2
3	Housekeeping	133,745	25,852		159,597		159,597		159,597			3
4	Laundry	105,883	12,243	1,797	119,923		119,923		119,923			4
5	Heat and Other Utilities			169,346	169,346		169,346		169,346			5
6	Maintenance	89,380	1,875	66,322	157,577		157,577		157,577			6
7	Other (specify):*											7
8	TOTAL General Services	720,806	361,192	250,995	1,332,993		1,332,993	(10)	1,332,983			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	2,348,868	83,758	78,785	2,511,411		2,511,411		2,511,411			10
10a	Therapy	673,205	960	249,808	923,973		923,973		923,973			10a
11	Activities	90,765	674	333	91,772		91,772		91,772			11
12	Social Services	52,269		746	53,015		53,015		53,015			12
13	CNA Training											13
14	Program Transportation		64		64		64		64			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,165,107	85,456	346,172	3,596,735		3,596,735		3,596,735			16
	C. General Administration											
17	Administrative	409,246		19,750	428,996	(16,250)	412,746	(506)	412,240			17
18	Directors Fees											18
19	Professional Services			758,187	758,187		758,187	(280,774)	477,413			19
20	Dues, Fees, Subscriptions & Promotions			10,885	10,885	16,250	27,135	(4,888)	22,247			20
21	Clerical & General Office Expenses		24,454	188,505	212,959		212,959	(55,015)	157,944			21
22	Employee Benefits & Payroll Taxes			705,463	705,463		705,463		705,463			22
23	Inservice Training & Education			459	459		459		459			23
24	Travel and Seminar			310	310		310		310			24
25	Other Admin. Staff Transportation			9,342	9,342		9,342	(9,342)				25
26	Insurance-Prop.Liab.Malpractice			99,151	99,151		99,151		99,151			26
27	Other (specify):*			9,564	9,564		9,564		9,564			27
28	TOTAL General Administration	409,246	24,454	1,801,616	2,235,316		2,235,316	(350,525)	1,884,791			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,295,159	471,102	2,398,783	7,165,044		7,165,044	(350,535)	6,814,509			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 HEALTHCARE & REHAB CENTER #0052449 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest			111,347	111,347		111,347		111,347			32
33	Real Estate Taxes			112,232	112,232		112,232	(660)	111,572			33
34	Rent-Facility & Grounds			1,919,933	1,919,933		1,919,933		1,919,933			34
35	Rent-Equipment & Vehicles			17,944	17,944		17,944		17,944			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,161,456	2,161,456		2,161,456	(660)	2,160,796			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			28,388	28,388		28,388		28,388			39
40	Barber and Beauty Shops	15,567			15,567		15,567		15,567			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			278,094	278,094		278,094		278,094			42
43	Other (specify):* Presc Drugs			228,885	228,885		228,885		228,885			43
44	**TOTAL Special Cost Centers**	15,567		535,367	550,934		550,934		550,934			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,310,726	471,102	5,095,606	9,877,434		9,877,434	(351,195)	9,526,239			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 HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10)	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	(55,015)	21		18
19	Entertainment	(506)	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	(4,888)	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)**	$ (60,419)		$	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)	(254,575)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (254,575)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (314,994)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PARK POINTE HEALTHCARE & REHAB CENTER

ID# 0052449

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VEHICLE RENT	$ (9,342)	25	1
2	UNALLOWABLE LEGAL FEES	(26,199)	19	2
3	ADJUST PROPERTY TAXES PD BY LESSOR	(660)	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**	(36,201)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARK POINTE HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10)	0	0	0	0	0	0	0	0	0	0	(10)	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**	(10)	0	0	0	0	0	0	0	0	0	0	(10)	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	(506)	0	0	0	0	0	0	0	0	0	0	(506)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(26,199)	(254,575)	0	0	0	0	0	0	0	0	0	(280,774)	19
20	Fees, Subscriptions & Promotions	(4,888)	0	0	0	0	0	0	0	0	0	0	(4,888)	20
21	Clerical & General Office Expenses	(55,015)	0	0	0	0	0	0	0	0	0	0	(55,015)	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	(9,342)	0	0	0	0	0	0	0	0	0	0	(9,342)	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**	(95,950)	(254,575)	0	0	0	0	0	0	0	0	0	(350,525)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(95,960)	(254,575)	0	0	0	0	0	0	0	0	0	(350,535)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK POINTE HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	(660)	0	0	0	0	0	0	0	0	0	0	(660)	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**	(660)	0	0	0	0	0	0	0	0	0	0	(660)	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)**	(96,620)	(254,575)	0	0	0	0	0	0	0	0	0	(351,195)	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
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. [ ] 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	$ 40,000	HORIZON HEALTHCARE. LLC	0.00%	$ 21,019	$ (18,981)	1
2	V	19	CONSULTING SERVICES	496,482	HORIZON HEALTHCARE. LLC	0.00%	260,888	(235,594)	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			$ 536,482			$ 281,907	$ * (254,575)	14

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

Facility Name & ID Number PARK POINTE HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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
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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 HEALTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	AARON WESTERKAMP	IT MANAGER	IT SERVICES	0.00	0	40	100.00	SALARY	$ 51,923	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	$ 126,923		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 HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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 HEALTHCARE & REHAB # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MERCHANTS BANK OF INDIANA		X	WORKING CAPITAL	NONE			1,969,195		5.2500	101,783	6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,969,195			$ 101,783	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 1,969,195			$ 101,783	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 HEALTHCARE & REHAB CENTER # 0052449 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2016 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.)	$	111,572	2
3. Under or (over) accrual (line 2 minus line 1).	$	111,572	3
4. Real Estate Tax accrual used for 2017 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.	$	111,572	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2012		8
	2013	67,844	9
	2014	101,885	10
	2015	108,406	11
	2016	108,406	12

FOR BHF USE ONLY

Line	Description		Amount	Line
13	FROM R. E. TAX STATEMENT FOR 2016	$		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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PARK POINTE HEALTHCARE & REHAB CENTER COUNTY GRUNDY

FACILITY IDPH LICENSE NUMBER 0052449

CONTACT PERSON REGARDING THIS REPORT SUZANNE DAY

TELEPHONE (815) 416-655 FAX #: (815) 416-6201

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 111,571.52	$ 111,571.52
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 111,571.52	$ 111,571.52

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

Facility Name & ID Number PARK POINTE HEALTHCARE & REHAB CENTER # 0052449 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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 HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 HEALTHCARE & REHAB CENTI # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 1,919,933	10	10	3
4	Additions							4
5								5
6								6
7	TOTAL		142		$ 1,919,933 **			7

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

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2018	$ 1500000 MINIMUM
13.	12/31/2019	$ 1500000 MINIMUM
14.	12/31/2020	$ 1500000 MINIMUM

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: ______ *

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 HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.

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	4741	hrs	$ 234,988	1,749	$ 87,160	$ 81	6,490	$ 322,229	1
2	Licensed Speech and Language Development Therapist	10A-1	1520	hrs	69,849	217	80,869		1,737	150,718	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A-1	4502	hrs	213,628	56	81,779	880	4,558	296,287	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				228,885		228,885	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				$ 518,465	2,022	$ 249,808	$ 229,846	12,785	$ 998,119	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 HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ (2,243,837)	$	1
2	Cash-Patient Deposits	15,938		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,642,581		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	92,414		6
7	Other Prepaid Expenses	56,424		7
8	Accounts Receivable (owners or related parties)	307,998		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 871,518	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	662,948		14
15	Leasehold Improvements, at Historical Cost	148,499		15
16	Equipment, at Historical Cost	100,646		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)**	$ 3,035,863	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,907,381	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,243,874	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,079		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	379,982		30
31	Accrued Taxes Payable (excluding real estate taxes)	67,713		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 Mgmt Fees/Insurance**	105,245		36
37	**Due to Medicaid**	33,909		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,835,802	$	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**	(159,104)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,807,511	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,643,313	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,134,362	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 13,777,675	$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 204,639	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 204,639	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	9,929,723	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)**	$ 9,929,723	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)**	$ 10,134,362	24 *

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

Facility Name & ID Number PARK POINTE HEALTHCARE & REHAB CENT # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 7,815,815	1
2	Discounts and Allowances for all Levels	(1,392,845)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,422,970	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,284,355	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,284,355	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	10	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	183,090	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	27,567	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 210,667	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	86	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 86	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellanous	11,645	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,645	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,929,723	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,332,993	31
32	Health Care	3,596,736	32
33	General Administration	2,225,751	33
	B. Capital Expense		
34	Ownership	2,161,455	34
	C. Ancillary Expense		
35	Special Cost Centers	272,840	35
36	Provider Participation Fee	278,094	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,867,869	40
41	**Income before Income Taxes (line 30 minus line 40)****	61,854	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 61,854	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,518,985	44
45	Private Pay - Net Inpatient Revenue	2,474,349	45
46	Medicare - Net Inpatient Revenue	866,180	46
47	Other-(specify) Hospice	547,613	47
48	Other-(specify) Insurance	15,843	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,422,970	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 HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	2,185	2,185	$ 72,113	$ 33.00	1
2	Assistant Director of Nursing	2,257	2,257	69,959	31.00	2
3	Registered Nurses	19,095	20,270	516,287	25.47	3
4	Licensed Practical Nurses	21,093	22,263	494,467	22.21	4
5	CNAs & Orderlies	95,041	98,260	1,138,713	11.59	5
6	CNA Trainees					6
7	Licensed Therapist	10,009	10,762	475,031	44.14	7
8	Rehab/Therapy Aides	6,313	6,760	198,174	29.32	8
9	Activity Director	2,049	2,185	27,605	12.63	9
10	Activity Assistants	5,288	5,384	63,160	11.73	10
11	Social Service Workers	3,327	3,777	52,269	13.84	11
12	Dietician	538	594	22,539	37.94	12
13	Food Service Supervisor	2,431	2,431	57,517	23.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,020	32,580	311,742	9.57	15
16	Dishwashers					16
17	Maintenance Workers	6,190	6,473	89,380	13.81	17
18	Housekeepers	13,472	14,118	133,745	9.47	18
19	Laundry	10,339	10,864	105,883	9.75	19
20	Administrator	2,160	2,320	118,870	51.24	20
21	Assistant Administrator	744	744	17,885	24.04	21
22	Other Administrative	9,096	9,408	135,625	14.42	22
23	Office Manager					23
24	Clerical	9,027	9,408	136,867	14.55	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	5,107	5,554	57,329	10.32	31
32	Other Health Care(specify)					32
33	Other(specify) Beauty & Barber	1,321	1,349	15,566	11.54	33
34	TOTAL (lines 1 - 33)	258,102	269,946	$ 4,310,726 *	$ 15.97	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		$		35
36	Medical Director		16,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		1,194	10-3	38
39	Pharmacist Consultant		9,069	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		748	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 27,511		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		16,046	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 16,046		53

Facility Name & ID Number PARK POINTE HEALTHCARE & REHAB CENTE # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

Description	Amount
Meals & Entertainment	$ 503
Taxes & Licenses	2,489
Minor Equipment	509
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 3,501

C. Professional Services

Vendor/Payee	Type	Amount
Chancery Court/Gibson Court	Legal	$ 854
Momkus McCluskey	Legal	73,891
O'neil, Parker & Williamson	Legal	6,055
Grove & Associates	Legal	345
Duane Morris LLP	Legal	8,065
Ability Network	Mcare Consulting	3,240
Point Click Care	EHR Platform	25,777
Horizon	Legal	25,000
Carr, Riggs & Ingram	Accounting/Data Processing	63,979
Michael Weisberg	Accounting	14,500
Horizon	Accounting Service	40,000
Horizon	Consulting/Management	496,481
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 758,187

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,459
Unemployment Compensation Insurance	32,350
FICA Taxes	324,318
Employee Health Insurance	262,746
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	4,590
TOTAL (agree to Schedule V, line 22, col.8)	$ 705,463

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 16,250
Advertising: Employee Recruitment	5,997
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	250
Advertising & Marketing	4,638
Less: Public Relations Expense	( )
Non-allowable advertising	(4,888)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,247

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	310
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 310

**See instructions.

Facility Name & ID Number PARK POINTE HEALTHCARE & REHAB CENTER # 0052449 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. **NO**

(3) Did the nursing home make political contributions or payments to a political action organization? **N/A** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **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. $ **24,402** 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. $ **278,094**
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	118,870
Debra Johnson	Office Staff	0	34,960
Aaron Westerkamp	Office Staff	0	51,923
Janet Struck	Bookkeeper	0	41,040
Kimberly Gordon	Bookkeeper	0	30,415
Lynn Marie-Paul	Bookkeeper	0	29,627
Roseann Taylor	Administrative	0	62,618
Rebecca Foster	Receptionist	0	3,616
Susan Darling	Receptionist	0	13,633
Becky Armstrong	Receptionist	0	10,875
Dana Bass	Receptionist	0	3,717
Sadie Kjellesvik	Receptionist	0	854
Kenne Durbin	Receptionist	0	7,099
Total			409,246

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

Vendor
CHANCERY COURT
MOMKUS MCCLUSKEY LLC
MOMKUS MCCLUSKEY LLC
MOMKUS MCCLUSKEY LLC
MOMKUS MCCLUSKEY LLC
MOMKUS MCCLUSKEY LLC
MOMKUS MCCLUSKEY LLC
MOMKUS MCCLUSKEY LLC /IN: 170131
MOMKUS MCCLUSKEY LLC /IN: 140751
MOMKUS MCCLUSKEY LLC /IN: 141756
MOMKUS MCCLUSKEY LLC /IN: 142798
MOMKUS MCCLUSKEY LLC /IN: 143947
MOMKUS MCCLUSKEY LLC /IN: 144607
O'NEIL, PARKER & WILLIAMSON
O'NEIL, PARKER & WILLIAMSON
O'NEIL, PARKER & WILLIAMSON
O'NEIL, PARKER & WILLIAMSON
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O'NEIL, PARKER & WILLIAMSON
O'NEIL, PARKER & WILLIAMSON
GROVE & ASSOCIATES REPORTING /IN: 6673
DUANE MORRIS LLP /IN: 2285188
DUANE MORRIS LLP /IN: 2294625
DUANE MORRIS LLP /IN: 2301403
GIBSON COURT REPORTING /IN: 85412
FUNCTIONAL PATHWAYS OF TN, LLC 002569
Horizon Healthcare
Horizon Healthcare

Date	Amount	Allowable Amount	Description
08 Dec 2017	703.50	0.00	Court Reporting fees
02 Oct 2017	2,994.17	2,994.17	Vendor lawsuit, prior owner
01 Dec 2017	200.00	200.00	Vendor lawsuit, prior owner
01 Jul 2017	2,255.50	2,255.50	Vendor lawsuit, prior owner
01 Aug 2017	1,190.00	1,190.00	Vendor lawsuit, prior owner
30 Nov 2017	400.00	400.00	Vendor lawsuit, prior owner
01 Sep 2017	14,886.22	14,886.22	Vendor lawsuit, prior owner
31 Jan 2017	3,801.78	3,801.78	Vendor lawsuit, prior owner
28 Feb 2017	3,258.00	3,258.00	Vendor lawsuit, prior owner
31 Mar 2017	9,085.00	9,085.00	Vendor lawsuit, prior owner
30 Apr 2017	1,240.00	1,240.00	Vendor lawsuit, prior owner
31 May 2017	19,869.17	19,869.17	Vendor lawsuit, prior owner
30 Jun 2017	11,083.50	11,083.50	Vendor lawsuit, prior owner
29 Sep 2017	1,284.00	1,284.00	Vendor lawsuit, prior owner
02 Nov 2017	240.00	240.00	Vendor lawsuit, prior owner
31 Jul 2017	504.00	504.00	Vendor lawsuit, prior owner
01 Jul 2017	1,448.50	1,448.50	Vendor lawsuit, prior owner
01 Jul 2017	408.00	408.00	Vendor lawsuit, prior owner
01 Jul 2017	896.00	896.00	Vendor lawsuit, prior owner
30 Apr 2017	126.00	126.00	Vendor lawsuit, prior owner
31 Jan 2017	1,106.00	1,106.00	Vendor lawsuit, prior owner
28 Feb 2017	42.00	42.00	Vendor lawsuit, prior owner
31 Mar 2017	345.40	0.00	Court Reporting fees
31 Jan 2017	5,423.50	5,423.50	Licensure Resurvey
31 Mar 2017	973.00	973.00	Licensure Resurvey
30 Apr 2017	1,668.00	1,668.00	Licensure Resurvey
31 May 2017	150.00	0.00	Court Reporting fees
31 May 2017	3,627.50	3,627.50	Vendor lawsuit, prior owner
31 Dec 2017	15,000.00	0.00	Unallowable legal fees
31 Oct 2017	10,000.00	0.00	Unallowable legal fees