

		FOR BHF USE				

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

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

<p><b>I. IDPH License ID Number:</b> <u>0052449</u></p> <p><b>Facility Name:</b> <u>PARK POINTE HEALTHCARE REHAB</u></p> <p><b>Address:</b> <u>1223 EDGEWATER DRIVE</u> <u>MORRIS</u> <u>60450</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>GRUNDY</u></p> <p><b>Telephone Number:</b> <u>(815) 416-6500</u> <b>Fax #</b> <u>(815) 416-6201</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>11/1/2013</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; vertical-align: top;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; vertical-align: top;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>SUZANNE DAY</u> <b>Telephone Number:</b> <u>(815) 416-6500</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p align="center">           I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.         </p> <p align="center">           Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.         </p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;"><b>Officer or Administrator of Provider</b></td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>SUZANNE DAY</u>            (Title) <u>ADMINISTRATOR</u> </td> </tr> <tr> <td style="width:20%; padding: 5px;"><b>Paid Preparer</b></td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) <u>BART MCCURLEY</u>  <u>CPA</u>            (Firm Name &amp; Address) <u>CARR, RIGGS &amp; INGRAM, LLC</u>  <u>1601 2ND AVE EAST ONEONTA, AL 35121</u>            (Telephone) <u>(205) 625-3472</u> <b>Fax #</b> <u>(205) 274-0182</u> </td> </tr> </table> <p align="center"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <span style="float: right;"><b>Phone # (217) 782-1630</b></span> </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>SUZANNE DAY</u> (Title) <u>ADMINISTRATOR</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) <u>BART MCCURLEY</u> <u>CPA</u> (Firm Name & Address) <u>CARR, RIGGS &amp; INGRAM, LLC</u> <u>1601 2ND AVE EAST ONEONTA, AL 35121</u> (Telephone) <u>(205) 625-3472</u> <b>Fax #</b> <u>(205) 274-0182</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>SUZANNE DAY</u> (Title) <u>ADMINISTRATOR</u>							
<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) <u>BART MCCURLEY</u> <u>CPA</u> (Firm Name & Address) <u>CARR, RIGGS &amp; INGRAM, LLC</u> <u>1601 2ND AVE EAST ONEONTA, AL 35121</u> (Telephone) <u>(205) 625-3472</u> <b>Fax #</b> <u>(205) 274-0182</u>							

Facility Name & ID Number PARK POINTE HEALTHCARE REHAB

# 0052449 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,327	8,500	6,636	33,463	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,327	8,500	6,636	33,463	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.39%**

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

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

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

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

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

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

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

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 142 and days of care provided 6,255

Medicare Intermediary NGS

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number **PARK POINTE HEALTHCARE REHAB** # **0052449** Report Period Beginning: **01/01/2020** Ending: **12/31/2020**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	345,929	27,479	7,749	381,157		381,157		381,157		1
2	Food Purchase		235,426		235,426		235,426		235,426		2
3	Housekeeping	123,880	36,391		160,271		160,271		160,271		3
4	Laundry	93,311	13,280	2,081	108,672		108,672		108,672		4
5	Heat and Other Utilities			143,305	143,305		143,305		143,305		5
6	Maintenance	120,203	4,313	55,610	180,126		180,126		180,126		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>683,323</b>	<b>316,889</b>	<b>208,745</b>	<b>1,208,957</b>		<b>1,208,957</b>		<b>1,208,957</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,177,161	170,319	(44,248)	2,303,232		2,303,232		2,303,232		10
10a	Therapy	665,633		85,000	750,633		750,633		750,633		10a
11	Activities	115,550	859	3,113	119,522		119,522		119,522		11
12	Social Services	83,044		1,685	84,729		84,729		84,729		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,041,388</b>	<b>171,178</b>	<b>63,550</b>	<b>3,276,116</b>		<b>3,276,116</b>		<b>3,276,116</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	511,895		5,400	517,295		517,295		517,295		17
18	Directors Fees										18
19	Professional Services			650,646	650,646		650,646	(258,042)	392,604		19
20	Dues, Fees, Subscriptions & Promotions			27,595	27,595		27,595	(27,154)	441		20
21	Clerical & General Office Expenses		16,511	172,101	188,612		188,612	(30,739)	157,873		21
22	Employee Benefits & Payroll Taxes			806,402	806,402		806,402	(15,506)	790,896		22
23	Inservice Training & Education			3,441	3,441		3,441		3,441		23
24	Travel and Seminar			1,844	1,844		1,844		1,844		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			389,077	389,077		389,077		389,077		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>511,895</b>	<b>16,511</b>	<b>2,056,506</b>	<b>2,584,912</b>		<b>2,584,912</b>	<b>(331,441)</b>	<b>2,253,471</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,236,606</b>	<b>504,578</b>	<b>2,328,801</b>	<b>7,069,985</b>		<b>7,069,985</b>	<b>(331,441)</b>	<b>6,738,544</b>		<b>29</b>

\*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 &amp; ID Number

PARK POINTE HEALTHCARE REHAB

#0052449

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest			233,967	233,967		233,967		233,967			32
33	Real Estate Taxes			64,759	64,759		64,759	(1,322)	63,437			33
34	Rent-Facility & Grounds			1,813,287	1,813,287		1,813,287		1,813,287			34
35	Rent-Equipment & Vehicles			18,301	18,301		18,301		18,301			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,130,314	2,130,314		2,130,314	(1,322)	2,128,992			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			12,118	12,118		12,118		12,118			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			256,779	256,779		256,779		256,779			42
43	Other (specify):*			183,321	183,321		183,321		183,321			43
44	<b>TOTAL Special Cost Centers</b>			452,218	452,218		452,218		452,218			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,236,606	504,578	4,911,333	9,652,517		9,652,517	(332,763)	9,319,754			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**

# **0052449**

Report Period Beginning:

**01/01/2020**

Ending:

**12/31/2020**

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(30,739)	21		18
19	Entertainment				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	(27,154)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (57,893)		\$	30

**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	2	
		<b>Amount</b>	<b>Reference</b>	
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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (57,893)		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	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	

PARK POINTE HEALTHCARE REHAB

ID# 0052449

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	PENALTIES	\$ (15,506)	22	1
2	UNALLOWABLE LEGAL FEES	(14,321)	19	2
3	ADJUST PROPERTY TAXES	(1,322)	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
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30				30
31				31
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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	<b>Total</b>	(31,149)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARK POINTE HEALTHCARE REHAB# 0052449

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,321)	(243,721)	0	0	0	0	0	0	0	0	0	(258,042)	19
20	Fees, Subscriptions & Promotions	(27,154)	0	0	0	0	0	0	0	0	0	0	(27,154)	20
21	Clerical & General Office Expenses	(30,739)	0	0	0	0	0	0	0	0	0	0	(30,739)	21
22	Employee Benefits & Payroll Taxes	(15,506)	0	0	0	0	0	0	0	0	0	0	(15,506)	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(87,720)</b>	<b>(243,721)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(331,441)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(87,720)</b>	<b>(243,721)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(331,441)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK POINTE HEALTHCARE REHAB # 0052449 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(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	(1,322)	0	0	0	0	0	0	0	0	0	0	(1,322) 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	<b>TOTAL Ownership</b>	<b>(1,322)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,322) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(89,042)</b>	<b>(243,721)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(332,763) 45</b>



**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 ACCOUNTING	\$ 30,000	HORIZON HEALTHCARE, LLC	0.00%	\$ 15,764	\$ (14,236)	1
2	V	19 MANAGEMENT FEES	483,608	HORIZON HEALTHCARE, LLC	0.00%	254,123	(229,485)	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		\$ 513,608			\$ 269,887	\$ * (243,721)	14

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

Facility Name & ID Number

PARK POINTE HEALTHCARE REHAB

# 0052449

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

**VII. RELATED PARTIES**

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number **PARK POINTE HEALTHCARE REHAB** # **0052449** Report Period Beginning: **01/01/2020** Ending: **12/31/2020**

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT WESTERKAMP	LLC MANAGER	LLC MANAGER	5.00	0	20	50.00	PMT OF SVC	\$ 75,000	21	1
2	AARON WESTERKAMP	IT MANAGER	IT SERVICES	0.00	0	40	100.00	SALARY	50,000	17	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 HEALTHCARE REHAB # 0052449 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

**PARK POINTE HEALTHCARE REHAB**

# **0052449**

Report Period Beginning:

**01/01/2020**

Ending:

**12/31/2020**

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
<b>Working Capital</b>																		
6	MERCHANTS BANK OF INDIANA	X	WORKING CAPITAL				2,002,321		6.2500	232,347	6							
7	MERCHANTS BANK OF INDIANA	X	WORKING CAPITAL				1,997,576		6.0000		7							
8											8							
9	<b>TOTAL Facility Related</b>					\$	\$ 3,999,897			\$ 232,347	9							
<b>B. Non-Facility Related*</b>																		
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>					\$	\$ 3,999,897			\$ 232,347	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.)

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2019 report.	\$	<b>63,437</b>	<b>1</b>
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.)	\$	<b>63,437</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$		<b>3</b>
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>63,437</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2015</b>	<b>108,406</b>	<b>8</b>
	<b>2016</b>	<b>108,406</b>	<b>9</b>
	<b>2017</b>	<b>111,572</b>	<b>10</b>
	<b>2018</b>	<b>110,950</b>	<b>11</b>
	<b>2019</b>	<b>63,425</b>	<b>12</b>

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

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

**2019 LONG TERM CARE REAL ESTATE TAX STATEMENT**

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-05-203-007</u>	<u>Nursing Home Land, Building</u>	\$ <u>63,437.32</u>	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>63,437.32</u>	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

**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.  (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 3 is shaded and labeled 'TOTALS'.



**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	4	
5										5	
6										6	
7										7	
8										8	
	<b>Improvement Type**</b>										
9										9	
10										10	
11										11	
12										12	
13										13	
14										14	
15										15	
16										16	
17										17	
18										18	
19										19	
20										20	
21										21	
22										22	
23										23	
24										24	
25										25	
26										26	
27										27	
28										28	
29										29	
30										30	
31										31	
32										32	
33										33	
34										34	
35										35	
36										36	

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

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

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

**XI. OWNERSHIP COSTS (continued)**

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$	\$	\$	\$		\$	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: **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	\$ 1,813,287	10	10 YR EXT	3
4	Additions							4
5								5
6								6
7	TOTAL		142		\$ 1,813,287			7

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.	<u>12/31/2021</u>	\$ <u>1500000 Minimum</u>
13.	<u>12/31/2022</u>	\$ <u>1500000 Minimum</u>
14.	<u>12/31/2023</u>	\$ <u>1500000 Minimum</u>

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  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 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.

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A-1	1931.25	hrs	\$ 79,659	549	\$ 28,333	\$	2,481	\$ 107,992	1
2	Licensed Speech and Language Development Therapist	10A-1	1446.00	hrs	72,300	567	28,333		2,013	100,633	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A-1	5531.50	hrs	270,802	607	28,333		6,139	299,135	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	15940	# of prescripts				183,321	15,940	183,321	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	<b>TOTAL</b>				\$ 422,761	1,723	\$ 84,999	\$ 183,321	26,572	\$ 691,081	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.

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (1,489,459)	\$	1
2	Cash-Patient Deposits	10,704		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,320,622		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	626,557		6
7	Other Prepaid Expenses	56,250		7
8	Accounts Receivable (owners or related parties)	3,275,124		8
9	Other(specify): <u>Retainer</u>	2,500		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,802,298	\$	10
	<b>B. Long-Term Assets</b>			
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	328,284		15
16	Equipment, at Historical Cost	103,918		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges	37,867		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	2,056,841		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,189,858	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,992,156	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 514,367	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,704		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	314,327		30
31	Accrued Taxes Payable (excluding real estate taxes)	733,102		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Mgmt Fees/Insurance</u>	607,890		36
37	<u>Due to Medicaid</u>	33,909		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,214,299	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	3,999,897		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,999,897	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,214,196	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 777,960	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,992,156	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>9,971,322</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior year adjustment</b>	<b>(9,866,585)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>104,737</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>20,824</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	<b>652,399</b>	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>673,223</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>777,960</b>	<b>24</b> *

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



**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

**classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

1			
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,004,526	1
2	Discounts and Allowances for all Levels	(288,228)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,716,298	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,788,573	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,788,573	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	161,703	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,765	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 164,468	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,172	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,172	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous</u>	2,828	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,828	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,673,339	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,208,957	31
32	Health Care	3,276,115	32
33	General Administration	2,584,910	33
<b>B. Capital Expense</b>			
34	Ownership	2,130,314	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	195,440	35
36	Provider Participation Fee	256,779	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,652,515	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	20,824	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 20,824	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,155,004	44
45	Private Pay - Net Inpatient Revenue	2,060,096	45
46	Medicare - Net Inpatient Revenue	2,485,503	46
47	Other-(specify) <u>Hospice</u>	15,695	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 7,716,298	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**

# **0052449**

Report Period Beginning: **01/01/2020**

Ending:

**12/31/2020**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,383	2,503	\$ 103,150	\$ 41.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,918	23,973	748,230	31.21	3
4	Licensed Practical Nurses	12,398	12,861	416,180	32.36	4
5	CNAs & Orderlies	59,498	61,553	886,302	14.40	5
6	CNA Trainees					6
7	Licensed Therapist	8,129	8,909	422,762	47.45	7
8	Rehab/Therapy Aides	6,657	7,723	242,871	31.45	8
9	Activity Director	1,930	2,080	34,320	16.50	9
10	Activity Assistants	6,624	6,988	81,230	11.62	10
11	Social Service Workers	3,776	3,961	83,044	20.97	11
12	Dietician	1,309	1,397	62,854	44.99	12
13	Food Service Supervisor	1,815	1,847	35,024	18.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,783	21,207	248,052	11.70	15
16	Dishwashers					16
17	Maintenance Workers	6,263	6,533	120,203	18.40	17
18	Housekeepers	10,272	10,616	123,880	11.67	18
19	Laundry	7,844	8,497	93,311	10.98	19
20	Administrator	1,992	2,104	132,180	62.82	20
21	Assistant Administrator					21
22	Other Administrative	6,607	6,831	106,046	15.52	22
23	Office Manager					23
24	Clerical	12,621	13,465	273,668	20.32	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	2,177	2,273	23,299	10.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	195,996	205,321	\$ 4,236,606 *	\$ 20.63	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	100	18,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	85	5,874	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	19	371	11-3	44
45	Social Service Consultant	41	1,685	12-3	45
46	Other(specify)	111	15,064	21-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	356	\$ 40,994		49

**C. CONTRACT NURSES**

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



Facility Name & ID Number **PARK POINTE HEALTHCARE REHAB**# **0052449**Report Period Beginning: **01/01/2020**Ending: **12/31/2020****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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,754 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 X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 256,779  
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? N/A  
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: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

Park Pointe Healthcare & Rehab Center, LLC

Provider: 0052449

XIX-A - Schedule of Administrative Salaries

Name	Function	Ownership %	Amount
Berry, Debra	Business Office	0	21,821
Cross, Kem	Receptionist	0	243
Cross, Kerri	Receptionist	0	3,823
Darling, Susan	Receptionist	0	14,029
Day, Suzanne	Administrator	0	132,180
Durbin, Kenne	Receptionist	0	12,145
Eichhorst, Crystal	Business Office	0	29,740
Foster, Rebecca	Receptionist	0	1,502
Frideres, Koren	Receptionist	0	6,781
Haight, Maria	Business Office	0	45,247
Harty, Janice	Receptionist	0	7,173
Hoop, Bridget	Receptionist	0	53
Jennings, Michelle	Business Office	0	5,669
Paul, Lynn Marie	Office Staff	0	31,120
Shark, Robbie	Office Staff	0	39,442
Sumner, Danielle	Office Staff	0	39,724
Taylor, Roseann	Administrative	0	60,299
Walden, Amanda	Business Office	0	7,452
Westerkamp, Aaron	Office Staff	0	50,000
Witowski, Sarah	Business Office	0	3,453
		0	
		0	
		0	
Total			511,895

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

Vendor	Date	Amount	Allowable Amount	Description
ACCELERATED CARE PLUS LEASING, INC	01 Mar 2020	508.99	0.00	Vendor Lawsuit
ACCELERATED CARE PLUS LEASING, INC	01 Apr 2020	508.99	0.00	Vendor Lawsuit
ACCELERATED CARE PLUS LEASING, INC	01 May 2020	508.99	0.00	Vendor Lawsuit
CYNTHIA CHOW & ASSOC LLC	01 Jan 2020	1,050.04	0.00	Unallowable Legal Fees
CYNTHIA CHOW & ASSOC LLC	01 Feb 2020	1,050.04	0.00	Unallowable Legal Fees
CYNTHIA CHOW & ASSOC LLC	01 Mar 2020	1,050.04	0.00	Unallowable Legal Fees
KNOX COUNTY CIRCUIT COURT	21 Aug 2020	272.50	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	21 Feb 2020	187.50	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	18 Mar 2020	532.95	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	20 Apr 2020	584.96	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	18 May 2020	750.00	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	10 Jun 2020	360.87	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	10 Jun 2020	508.13	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	18 Jun 2020	432.50	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	06 Jul 2020	125.00	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	18 Aug 2020	170.00	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	21 Sep 2020	187.50	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	20 Oct 2020	62.50	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	15 Jan 2020	14.42	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	15 Jan 2020	73.12	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	15 Jan 2020	26.78	0.00	Vendor Lawsuit
MALMQUIST, GEIGER & DURKEE	15 Jan 2020	562.36	0.00	Vendor Lawsuit
SWANSON, MARTIN & BELL, LLP	29 Sep 2020	870.00	0.00	Vendor Lawsuit
SWANSON, MARTIN & BELL, LLP	17 Oct 2020	100.00	0.00	Vendor Lawsuit
SWANSON, MARTIN & BELL, LLP	17 Feb 2020	160.00	0.00	Vendor Lawsuit
SWANSON, MARTIN & BELL, LLP	09 Jun 2020	280.00	0.00	Vendor Lawsuit
SWANSON, MARTIN & BELL, LLP	12 Aug 2020	640.00	0.00	Vendor Lawsuit
SWANSON, MARTIN & BELL, LLP	31 Dec 2020	1,142.50	0.00	Unallowable Legal Fees
SWANSON, MARTIN & BELL, LLP	31 Dec 2020	760.00	0.00	Unallowable Legal Fees
SWANSON, MARTIN & BELL, LLP	09 Jun 2020	280.00	280.00	Vendor Lawsuit, prior owner
SWANSON, MARTIN & BELL, LLP	15 May 2020	160.00	160.00	Vendor Lawsuit, prior owner
SWANSON, MARTIN & BELL, LLP	13 Apr 2020	840.00	0.00	Unallowable Legal Fees
VEDDER PRICE PC - Union	12 Mar 2020	6,200.00	6,200.00	General labor & employment advice
		20,960.68	6,640.00	