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|  |  | FOR BHF USE |  |  |  |
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**Supportive Living Facility**

**2020  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2020)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

|   |  |  |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
|---|--|--|---|--------------------------------|--|---------------------------------|---------------------------------|--|--------------------------------------|--|---|--|--|--------------------------------|--|--|--------------------------------------|--|---|--------------------------------------|-----------------------------|--|---|--|------------------------|---------------|--|--|--|--|--|--|---|
| <p><b>I. Facility ID Number:</b> <u>1000037</u></p> <p><b>Facility Name:</b> <u>POINTE AT JACKSONVILLE</u></p> <hr/> <p><b>Address:</b> <u>20 JACKSONVILLE PL</u> <u>JACKSONVILLE</u> <u>62650</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>MORGAN</u></p> <p><b>Telephone Number:</b> <u>( 217 ) 245-5101</u> <b>Fax #</b> <u>( 217 ) 245-2000</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>10/1/2019</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY Individual</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership Corporation</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> _____</td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> | <input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.  | <input checked="" type="checkbox"/> PROPRIETARY Individual | <input type="checkbox"/> GOVERNMENTAL State | <input type="checkbox"/> Trust | <input type="checkbox"/> Partnership Corporation | <input type="checkbox"/> County | <b>IRS Exemption Code</b> _____ | <input type="checkbox"/> "Sub-S" Corp. | <input type="checkbox"/> Other _____ |  | <input checked="" type="checkbox"/> Limited Liability Co. |  |  | <input type="checkbox"/> Trust |  |  | <input type="checkbox"/> Other _____ |  | <p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</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>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;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>MICHAEL STEIN</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>MANAGER</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) <u>KATHLEEN MCNAMARA VICE-PRESIDENT</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name &amp; Address) <u>KBKB, LTD. 6201 W. HOWARD ST., SUITE 201 NILES IL 60714</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) <u>( 847 ) 675-3585</u> Fax <u>( 847 ) 675-5777</u></td> </tr> </table> | Officer or Administrator of Provider | (Signed) _____ (Date) _____ |  | (Type or Print Name) <u>MICHAEL STEIN</u> |  | (Title) <u>MANAGER</u> | Paid Preparer | (Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____ |  | (Print Name and Title) <u>KATHLEEN MCNAMARA VICE-PRESIDENT</u> |  | (Firm Name & Address) <u>KBKB, LTD. 6201 W. HOWARD ST., SUITE 201 NILES IL 60714</u> |  | (Telephone) <u>( 847 ) 675-3585</u> Fax <u>( 847 ) 675-5777</u> |
| <input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.   | <input checked="" type="checkbox"/> PROPRIETARY Individual   | <input type="checkbox"/> GOVERNMENTAL State                |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
| <input type="checkbox"/> Trust  | <input type="checkbox"/> Partnership Corporation   | <input type="checkbox"/> County                            |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
| <b>IRS Exemption Code</b> _____   | <input type="checkbox"/> "Sub-S" Corp.   | <input type="checkbox"/> Other _____                       |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
|   | <input checked="" type="checkbox"/> Limited Liability Co.  |  |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
|   | <input type="checkbox"/> Trust   |  |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
|   | <input type="checkbox"/> Other _____   |  |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
| Officer or Administrator of Provider  | (Signed) _____ (Date) _____  |  |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
|   | (Type or Print Name) <u>MICHAEL STEIN</u>  |  |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
|   | (Title) <u>MANAGER</u>   |  |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
| Paid Preparer   | (Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____   |  |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
|   | (Print Name and Title) <u>KATHLEEN MCNAMARA VICE-PRESIDENT</u>   |  |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
|   | (Firm Name & Address) <u>KBKB, LTD. 6201 W. HOWARD ST., SUITE 201 NILES IL 60714</u>   |  |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
|   | (Telephone) <u>( 847 ) 675-3585</u> Fax <u>( 847 ) 675-5777</u>  |  |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |
| <p><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>KATHLEEN MCNAMARA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u></p> <p><b>Email Address:</b> _____</p>  | <p><b>MAIL TO: BUREAU OF HEALTH FINANCE<br/>IL DEPT OF HEALTHCARE AND FAMILY SERVICES<br/>201 S. Grand Avenue East<br/>Springfield, IL 62763-0001</b></p> <p align="right"><b>Phone # (217) 782-1630</b></p> |  |   |                                |  |                                 |                                 |  |                                      |  |   |  |  |                                |  |  |                                      |  |   |                                      |                             |  |   |  |                        |               |  |  |  |  |  |  |   |



Facility Name: POINTE AT JACKSONVILLE

Report Period Beginning:

1/1/2020

Ending: 12/31/2020

## IV. COST CENTER EXPENSES (please round to the nearest dollar)

| Operating Expenses                 |   | Costs Per General Ledger |               |            |            | Reclassifications<br>and Adjustments | Adjusted<br>Total |    |
|------------------------------------|---|--------------------------|---------------|------------|------------|--------------------------------------|-------------------|----|
|                                    |   | Salary/Wage<br>1         | Supplies<br>2 | Other<br>3 | Total<br>4 |                                      |                   |    |
| <b>A. General Services</b>         |   |                          |               |            |            |                                      |                   |    |
| 1                                  | Dietary and Food Purchase                                     | 257,942                  | 230,102       | 3,842      | 491,886    |                                      | 491,886           | 1  |
| 2                                  | Housekeeping, Laundry and Maintenance                         | 153,561                  | 84,200        | 117,152    | 354,913    | 8,849                                | 363,762           | 2  |
| 3                                  | Heat and Other Utilities                                      |                          |               | 137,293    | 137,293    | (56,990)                             | 80,303            | 3  |
| 4                                  | Other (specify): Scavenger & Exterminating Service            |                          |               | 15,949     | 15,949     |                                      | 15,949            | 4  |
| 5                                  | <b>TOTAL General Services</b>                                 | 411,503                  | 314,302       | 274,236    | 1,000,041  | (48,141)                             | 951,900           | 5  |
| <b>B. Health Care and Programs</b> |   |                          |               |            |            |                                      |                   |    |
| 6                                  | Health Care/ Personal Care                                    | 383,417                  | 83,704        | 18         | 467,139    |                                      | 467,139           | 6  |
| 7                                  | Activities and Social Services                                | 29,901                   | 23,083        |            | 52,984     |                                      | 52,984            | 7  |
| 8                                  | Other (specify):  |                          |               |            |            |                                      |                   | 8  |
| 9                                  | <b>TOTAL Health Care and Programs</b>                         | 413,318                  | 106,787       | 18         | 520,123    |                                      | 520,123           | 9  |
| <b>C. General Administration</b>   |   |                          |               |            |            |                                      |                   |    |
| 10                                 | Administrative and Clerical                                   | 137,052                  | 23,001        | 138,930    | 298,983    | 482                                  | 299,465           | 10 |
| 11                                 | Marketing Materials, Promotions and Advertising               | 28,564                   |               | 58,389     | 86,953     |                                      | 86,953            | 11 |
| 12                                 | Employee Benefits and Payroll Taxes                           |                          |               | 176,790    | 176,790    |                                      | 176,790           | 12 |
| 13                                 | Insurance-Property, Liability and Malpractice                 |                          |               | 47,063     | 47,063     | 13,524                               | 60,587            | 13 |
| 14                                 | Other (specify):  |                          |               |            |            |                                      |                   | 14 |
| 15                                 | <b>TOTAL General Administration</b>                           | 165,616                  | 23,001        | 421,172    | 609,789    | 14,006                               | 623,795           | 15 |
| 16                                 | <b>TOTAL Operating Expense<br/>(Sum of lines 5, 9 and 15)</b> | 990,437                  | 444,090       | 695,426    | 2,129,953  | (34,135)                             | 2,095,818         | 16 |
| <b>Capital Expenses</b>            |   |                          |               |            |            |                                      |                   |    |
| <b>D. Ownership</b>                |   |                          |               |            |            |                                      |                   |    |
| 17                                 | Depreciation  |                          |               |            |            | 299,049                              | 299,049           | 17 |
| 18                                 | Interest  |                          |               | 49,852     | 49,852     | 273,328                              | 323,180           | 18 |
| 19                                 | Real Estate Taxes   |                          |               |            |            | 68,317                               | 68,317            | 19 |
| 20                                 | Rent -- Facility and Grounds                                  |                          |               | 542,082    | 542,082    | (542,082)                            |                   | 20 |
| 21                                 | Rent -- Equipment   |                          |               | 17,116     | 17,116     |                                      | 17,116            | 21 |
| 22                                 | Other (specify): Mortgage Insurance                           |                          |               |            |            | 34,133                               | 34,133            | 22 |
| 23                                 | <b>TOTAL Ownership</b>  |                          |               | 609,050    | 609,050    | 132,745                              | 741,795           | 23 |
| 24                                 | <b>GRAND TOTAL (Sum of lines 16 and 23)</b>                   | 990,437                  | 444,090       | 1,304,476  | 2,739,003  | 98,610                               | 2,837,613         | 24 |

Facility Name: POINTE AT JACKSONVILLE

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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

|    | Personnel                      | Number of FTE | Average Hourly Wage |           |
|----|--------------------------------|---------------|---------------------|-----------|
| 1  | Registered Nurses              |               | \$                  | 1         |
| 2  | Licensed Practical Nurses      | 1             | 21.00               | 2         |
| 3  | Certified Nurse Assistants     | 8             | 13.23               | 3         |
| 4  | Activity Director & Assistants | 1             | 15.00               | 4         |
| 5  | Social Service Workers         |               |                     | 5         |
| 6  | Head Cook                      | 1             | 20.00               | 6         |
| 7  | Cook Helpers/Assistants        | 9             | 10.94               | 7         |
| 8  | Dishwashers                    |               |                     | 8         |
| 9  | Maintenance Workers            | 1             | 19.54               | 9         |
| 10 | Housekeepers                   | 2             | 11.49               | 10        |
| 11 | Laundry                        |               |                     | 11        |
| 12 | Managers                       | 1             | 16.00               | 12        |
| 13 | Other Administrative           | 1             | 28.84               | 13        |
| 14 | Clerical Admin. Assistant      | 1             | 20.00               | 14        |
| 15 | Marketing                      |               |                     | 15        |
| 16 | Other Director of Nursing      | 1             | 26.00               | 16        |
| 17 | <b>Total (lines 1 thru 16)</b> | <b>27</b>     | <b>\$ 14.51</b>     | <b>17</b> |

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

|   | NAME and FUNCTION | Ownership Interest | Average Hours Per Work Week Devoted to this Business | Amount of Compensation for this Reporting Period |           |          |
|---|-------------------|--------------------|--|--|-----------|----------|
| 1 |                   |                    |  | \$   | 1         |          |
| 2 |                   |                    |  |  | 2         |          |
| 3 |                   |                    |  |  | 3         |          |
| 4 |                   |                    |  |  | 4         |          |
| 5 |                   |                    |  |  | 5         |          |
|   |                   |                    |  | <b>Total</b>                                     | <b>\$</b> | <b>6</b> |

VI. (B) Management fees paid to unrelated parties

|              | Amount of Fee |           |          |
|--------------|---------------|-----------|----------|
| 1            | \$            | 1         |          |
| 2            |               | 2         |          |
| <b>Total</b> |               | <b>\$</b> | <b>3</b> |

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

| Name                           | 1 | City      | 2 |
|--------------------------------|---|-----------|---|
| PARK POINT SUPPORTIVE LIVING   |   | MORRIS    |   |
| PONTIAC SUPPORTIVE LIVING      |   | PONTIAC   |   |
| CRYSTAL CREEK ASSISTANT LIVING |   | CANTON MI |   |
| THE POINTE AT KILPATRICK       |   | CRESTWOOD |   |

OTHER RELATED BUSINESS ENTITIES

| Name                      | 3 | City         | 4 | Type of Business | 5 |
|---------------------------|---|--------------|---|------------------|---|
| JACKSONVILLE LANDLORD LLC |   | JACKSONVILLE |   | PROPCO           |   |
|                           |   |              |   |                  |   |
|                           |   |              |   |                  |   |

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES  NO

Name of related entity: \_\_\_\_\_ If yes, what is the value of those services? \$ \_\_\_\_\_  
 (Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES  NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: POINTE AT JACKSONVILLE

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VIII. OWNERSHIP COSTS

A. Purchase price of land \_\_\_\_\_ Year land was acquired \_\_\_\_\_

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar.

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

|                         | 1<br>Units* | FOR BHF USE ONLY                  | 2<br>Year<br>Acquired | 3<br>Year<br>Constructed | 4<br>Cost    | 5<br>Current Book<br>Depreciation | 6<br>Life<br>in Years | 7<br>Straight Line<br>Depreciation | 8<br>Adjustments | 9<br>Accumulated<br>Depreciation |    |
|-------------------------|-------------|-----------------------------------|-----------------------|--------------------------|--------------|-----------------------------------|-----------------------|------------------------------------|------------------|----------------------------------|----|
| 1                       |             |                                   |                       |                          | \$           | \$                                |                       | \$                                 | \$               | \$                               | 1  |
| 2                       | 86          |                                   | 2019                  |                          | 7,878,418    | 286,488                           | 27.5                  | 286,488                            |                  | 322,299                          | 2  |
| 3                       |             |                                   |                       |                          |              |                                   |                       |                                    |                  |                                  | 3  |
| 4                       |             |                                   |                       |                          |              |                                   |                       |                                    |                  |                                  | 4  |
| 5                       |             |                                   |                       |                          |              |                                   |                       |                                    |                  |                                  | 5  |
| <b>Improvement Type</b> |             |                                   |                       |                          |              |                                   |                       |                                    |                  |                                  |    |
| 6                       |             | WATERPROOF EMERGENCY PULL STATION | 2019                  |                          | 26,923       | 979                               | 27.5                  | 979                                |                  | 1,061                            | 6  |
| 7                       |             | AUDIO SYSTEM                      | 2019                  |                          | 47,000       | 1,709                             | 27.5                  | 1,709                              |                  | 1,851                            | 7  |
| 8                       |             | WIRING                            | 2019                  |                          | 12,000       | 436                               | 27.5                  | 436                                |                  | 472                              | 8  |
| 9                       |             | RELIAS                            | 2019                  |                          | 1,889        | 69                                | 27.5                  | 69                                 |                  | 77                               | 9  |
| 10                      |             | SONOS AUDIO SYSTEMS               | 2020                  |                          | 16,150       | 587                               | 27.5                  | 587                                |                  | 587                              | 10 |
| 11                      |             | INSTALLED NEW WIFI ENDPOLNTS      | 2020                  |                          | 7,654        | 278                               | 27.5                  | 278                                |                  | 278                              | 11 |
| 12                      |             | BATH AND SHOWER REMODEL           | 2020                  |                          | 140,386      | 2,552                             | 27.5                  | 2,552                              |                  | 2,552                            | 12 |
| 13                      |             | FLOORING                          | 2020                  |                          | 66,518       | 806                               | 27.5                  | 806                                |                  | 806                              | 13 |
| 14                      |             | CABLE SYSTEM                      | 2020                  |                          | 13,792       | 418                               | 27.5                  | 418                                |                  | 418                              | 14 |
| 15                      |             | PHONE SYSTEM                      | 2020                  |                          | 28,600       | 347                               | 27.5                  | 347                                |                  | 347                              | 15 |
| 16                      |             | WIRING PROJECT                    | 2020                  |                          | 6,118        | 37                                | 27.5                  | 37                                 |                  | 37                               | 16 |
| 17                      |             | TOTAL (lines 1 thru 16)           |                       |                          | \$ 8,245,448 | \$ 294,706                        |                       | \$ 294,706                         | \$               | \$ 330,785                       | 17 |

C. Equipment Depreciation -- Including Transportation.

|    | Type                    | 1<br>Cost | 2<br>Current Book<br>Depreciation | 3<br>Straight Line<br>Depreciation | 4<br>Adjustments | 5<br>Life<br>in Years | 6<br>Accumulated<br>Depreciation |    |
|----|-------------------------|-----------|-----------------------------------|------------------------------------|------------------|-----------------------|----------------------------------|----|
| 18 | Movable Equipment       | \$ 54,075 | \$ 4,343                          | \$ 2,704                           | (1,639)          | 10                    | \$ 2,704                         | 18 |
| 19 | Vehicles                |           |                                   |                                    |                  |                       |                                  | 19 |
| 20 | TOTAL (lines 18 and 19) | \$ 54,075 | \$ 4,343                          | \$ 2,704                           | (1,639)          |                       | \$ 2,704                         | 20 |

D. Depreciable Non-Care Assets Included in General Ledger.

|    | 1<br>Description and Year Acquired | 2<br>Cost | 3<br>Current Book<br>Depreciation | 4<br>Accumulated<br>Depreciation |    |
|----|------------------------------------|-----------|-----------------------------------|----------------------------------|----|
| 21 |                                    | \$        | \$                                | \$                               | 21 |
| 22 |                                    |           |                                   |                                  | 22 |
| 23 |                                    |           |                                   |                                  | 23 |
| 24 | TOTALS (lines 21, 22 and 23)       | \$        | \$                                | \$                               | 24 |



Facility Name: **POINTE AT JACKSONVILLE**Report Period Beginning: **1/1/2020**

Ending:

**12/31/2020****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2020

(last day of reporting year)

|    |   | 1<br>Operating | 2<br>After<br>Consolidation* |    |
|----|---|----------------|------------------------------|----|
|    | <b>A. Current Assets</b>  |                |                              |    |
| 1  | Cash on Hand and in Banks   | \$ 493,664     | \$ 562,389                   | 1  |
| 2  | Cash-Patient Deposits   |                |                              | 2  |
| 3  | Accounts & Short-Term Notes Receivable-Patients (less allowance ) | 138,837        | 138,837                      | 3  |
| 4  | Supply Inventory (priced at )                                     |                |                              | 4  |
| 5  | Short-Term Investments  |                |                              | 5  |
| 6  | Prepaid Insurance   | 14,688         | 42,231                       | 6  |
| 7  | Other Prepaid Expenses  | 1,333          | 1,333                        | 7  |
| 8  | Accounts Receivable (owners or related parties)                   | 1,000,000      | 1,000,000                    | 8  |
| 9  | Other(specify): <b>ESCROWS</b>                                    |                | 330,736                      | 9  |
| 10 | <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>               | \$ 1,648,522   | \$ 2,075,526                 | 10 |
|    | <b>B. Long-Term Assets</b>  |                |                              |    |
| 11 | Long-Term Notes Receivable  |                |                              | 11 |
| 12 | Long-Term Investments   |                |                              | 12 |
| 13 | Land  |                | 250,000                      | 13 |
| 14 | Buildings, at Historical Cost                                     |                | 7,878,418                    | 14 |
| 15 | Leasehold Improvements, at Historical Cost                        |                | 367,030                      | 15 |
| 16 | Equipment, at Historical Cost                                     |                | 54,075                       | 16 |
| 17 | Accumulated Depreciation (book methods)                           |                | (335,128)                    | 17 |
| 18 | Deferred Charge <b>Deferred Loan Costs-Net</b>                    |                | 29,991                       | 18 |
| 19 | Organization & Pre-Operating Costs                                |                |                              | 19 |
| 20 | Accumulated Amortization - Organization & Pre-Operating Costs     |                |                              | 20 |
| 21 | Restricted Funds  |                |                              | 21 |
| 22 | Other Long-Term Assets (specify):                                 |                |                              | 22 |
| 23 | Other(specify): <b>Deposit on Fixed Assets</b>                    |                | 3,840                        | 23 |
| 24 | <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>           | \$             | \$ 8,248,226                 | 24 |
| 25 | <b>TOTAL ASSETS (sum of lines 10 and 24)</b>                      | \$ 1,648,522   | \$ 10,323,752                | 25 |

|    |  | 1<br>Operating | 2<br>After<br>Consolidation* |    |
|----|--|----------------|------------------------------|----|
|    | <b>C. Current Liabilities</b>                                |                |                              |    |
| 26 | Accounts Payable   | \$ 6,668       | \$ 6,668                     | 26 |
| 27 | Officer's Accounts Payable                                   | 911,973        | 911,973                      | 27 |
| 28 | Accounts Payable-Patient Deposits                            | 500            | 78,038                       | 28 |
| 29 | Short-Term Notes Payable                                     |                | 104,422                      | 29 |
| 30 | Accrued Salaries Payable                                     | 29,778         |                              | 30 |
| 31 | Accrued Taxes Payable  | 2,823          | 68,823                       | 31 |
| 32 | Accrued Interest Payable                                     |                | 18,436                       | 32 |
| 33 | Deferred Compensation  |                |                              | 33 |
| 34 | Federal and State Income Taxes                               |                |                              | 34 |
|    | <b>Other Current Liabilities(specify):</b>                   |                |                              |    |
| 35 | <b>SBA PPP LOAN</b>  | 235,500        | 235,500                      | 35 |
| 36 |  |                |                              | 36 |
| 37 | <b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>   | \$ 1,187,242   | \$ 1,423,860                 | 37 |
|    | <b>D. Long-Term Liabilities</b>                              |                |                              |    |
| 38 | Long-Term Notes Payable                                      |                |                              | 38 |
| 39 | Mortgage Payable   |                | 6,681,897                    | 39 |
| 40 | Bonds Payable  |                |                              | 40 |
| 41 | Deferred Compensation  |                |                              | 41 |
|    | <b>Other Long-Term Liabilities(specify):</b>                 |                |                              |    |
| 42 |  |                |                              | 42 |
| 43 |  |                |                              | 43 |
| 44 | <b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b> | \$             | \$ 6,681,897                 | 44 |
| 45 | <b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>            | \$ 1,187,242   | \$ 8,105,757                 | 45 |
| 46 | <b>TOTAL EQUITY</b>  | \$ 461,280     | \$ 2,217,995                 | 46 |
| 47 | <b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b> | \$ 1,648,522   | \$ 10,323,752                | 47 |

\*(See instructions.)

Facility Name: POINTE AT JACKSONVILLE

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

## XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

|                                    |  | 1                   |    |
|------------------------------------|--|---------------------|----|
| I. Revenue                         |  | Amount              |    |
| <b>A. SLF Resident Care</b>        |  |                     |    |
| 1                                  | Gross SLF Resident Revenue                                       | \$ 2,524,546        | 1  |
| 2                                  | Discounts and Allowances   |                     | 2  |
| 3                                  | <b>SUBTOTAL Resident Care (line 1 minus line 2)</b>              | <b>\$ 2,524,546</b> | 3  |
| <b>B. Other Operating Revenue</b>  |  |                     |    |
| 4                                  | Special Services   | 1,340               | 4  |
| 5                                  | Other Health Care Services                                       |                     | 5  |
| 6                                  | Special Grants   |                     | 6  |
| 7                                  | Gift and Coffee Shop   |                     | 7  |
| 8                                  | Barber and Beauty Care   |                     | 8  |
| 9                                  | Non-Resident Meals   |                     | 9  |
| 10                                 | Laundry  |                     | 10 |
| 11                                 | <b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b> | <b>\$ 1,340</b>     | 11 |
| <b>C. Non-Operating Revenue</b>    |  |                     |    |
| 12                                 | Contributions  |                     | 12 |
| 13                                 | Interest and Other Investment Income                             |                     | 13 |
| 14                                 | <b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>   | <b>\$</b>           | 14 |
| <b>D. Other Revenue (specify):</b> |  |                     |    |
| 15                                 | <b>FOOD STAMP INCOME</b>   | <b>54,306</b>       | 15 |
| 16                                 | <b>STIMULUS PAYMENT</b>  | <b>137,713</b>      | 16 |
| 17                                 | <b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>           | <b>\$ 192,019</b>   | 17 |
| 18                                 | <b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>             | <b>\$ 2,717,905</b> | 18 |

|  |  | 2                   |    |
|--|--|---------------------|----|
| II. Expenses   |  | Amount              |    |
| <b>A. Operating Expenses</b>                                   |  |                     |    |
| 19   | General Services   | 1,000,041           | 19 |
| 20   | Health Care/ Personal Care                                     | 520,123             | 20 |
| 21   | General Administration   | 609,789             | 21 |
| <b>B. Capital Expense</b>                                      |  |                     |    |
| 22   | Ownership  | 609,050             | 22 |
| <b>C. Other Expenses</b>                                       |  |                     |    |
| 23   | Special Cost Centers   |                     | 23 |
| 24   | Non-Operating Expenses   |                     | 24 |
| 25   | Other (specify):   |                     | 25 |
| 26   | <b>PRIOR YEAR ADJUSTMENT</b>                                   | <b>70,192</b>       | 26 |
| 27   |  |                     | 27 |
| 28   | <b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>                | <b>\$ 2,809,195</b> | 28 |
| 29   | <b>Income Before Income Taxes (line 18 minus line 28)</b>      | <b>\$ (91,290)</b>  | 29 |
| 30   | <b>Income Taxes</b>  | <b>\$</b>           | 30 |
| 31   | <b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b> | <b>\$ (91,290)</b>  | 31 |
| <b>III. Net Resident Care Revenue detailed by Payer Source</b> |  |                     |    |
| 32   | Medicaid - Net Inpatient Revenue                               | \$ 1,540,661        | 32 |
| 33   | Private Pay - Net Inpatient Revenue                            | 983,885             | 33 |
| 34   | Medicare - Net Inpatient Revenue                               |                     | 34 |
| 35   | Other-(specify)  |                     | 35 |
| 36   | Other-(specify)  |                     | 36 |
| 37   | <b>TOTAL (This total must agree to Line 3)</b>                 | <b>\$ 2,524,546</b> | 37 |

THE POINTE AT JACKSONVILLE, LLC  
01/01/2020-12/31/2020

| DESCRIPTION                    | AMOUNT   |
|--------------------------------|----------|
| LINE 3 CABLE TV-RESIDENT ROOMS | (56,990) |
| LINE 10 CONTRIBUTIONS          | (1,050)  |

RELATED PARTY LANDLORD

|                             |           |
|-----------------------------|-----------|
| LINE 20 RENT                | (542,082) |
| LINE 2 REPAIR & MAINTENANCE | 8,849     |
| LINE 10 PROFESSIONAL FEES   | 1,532     |
| LINE 13 INSURANCE-PROPERTY  | 13,524    |
| LINE 17 DEPRECIATION        | 299,049   |
| LINE 18 MORTGAGE INTEREST   | 273,328   |
| LINE 19 REAL ESTATE TAXES   | 68,317    |
| LINE 22 MORTGAGE INSURANCE  | 34,133    |
| LINE 24 GRAND TOTAL         | 98,610    |