

		FOR BHF USE			

LL2

Supportive Living Facility

2015

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2015)

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.

I. Facility ID Number: 1000033

Facility Name: THE POINTE AT KILPATRICK

Address: 14230 S KILPATRICK CRESTWOOD 60445

County: COOK

Telephone Number: ( 708 ) 293-0010 Fax # (708) 293-0020

Federal Employer ID Number:

Date Current Owners were Certified: 12/01/03

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:

Name: SANFORD BOKOR Telephone Number: ( 847 ) 675-3585

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2015 to 12/31/2015 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) MICHAEL STEIN	
Paid Preparer	(Title) MANAGER	
	(Signed) _____	(SEE ATTACHED ACCOUNTANT'S REPORT)
	(Print Name and Title) SANFORD BOKOR PRESIDENT	
	(Firm Name & Address) KBKB, LTD 8140 RIVER DRIVE, MORTON GROVE, IL 60053	
	(Telephone) (847 ) 675-3585 Fax (847) 675-5777	

MAIL TO: BUREAU OF HEALTH FINANCE

IL DEPT OF HEALTHCARE AND FAMILY SERVICES

201 S. Grand Avenue East

Springfield, IL 62763-0001

Phone # (217) 782-1630

Facility Name THE POINTE AT KILPATRICK

Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	44	Single Unit Apartment	44	16,060	1
2	78	Double Unit Apartment	78	28,470	2
3		Other			3
4	122	TOTALS	122	44,530	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	19,205	7,023		26,228	5
6	Double Unit	8,548	5,385		13,933	6
7	Other					7
8	TOTALS	27,753	12,408		40,161	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.19%

D. Indicate the number of paid bed-hold days the SLF had during this year  
Also, indicate the number of unpaid bed-hold days the SLF had during this year. (Do not include bed-hold days in Section B.)

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES NO X

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO X

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH\* CASH\*

I. Is your fiscal year identical to your tax year? X YES NO

Tax Year: 2015 Fiscal Year: 2015

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? NO If yes, did the facility make all of the required payments of interest and principle? If no, explain.

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? NO If yes, did the facility make all of the required payments of interest and principle? If no, explain.

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? NO If yes, did the facility make all of the required payments of interest and principle? If no, explain.

## STATE OF ILLINOIS

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Facility Name: THE POINTE AT KILPATRICK

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
	<b>A. General Services</b>							
1	Dietary and Food Purchase	230,824	318,637	1,917	551,378	(1,916)	549,462	1
2	Housekeeping, Laundry and Maintenance	131,898	50,092	130,914	312,904		312,904	2
3	Heat and Other Utilities			127,500	127,500	(4,601)	122,899	3
4	Other (specify): Scavenger and Exterminating Service			9,913	9,913		9,913	4
5	<b>TOTAL General Services</b>	362,722	368,729	270,244	1,001,695	(6,517)	995,178	5
	<b>B. Health Care and Programs</b>							
6	Health Care/ Personal Care	457,221	12,467	8,190	477,878		477,878	6
7	Activities and Social Services	66,730	14,099		80,829		80,829	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	523,951	26,566	8,190	558,707		558,707	9
	<b>C. General Administration</b>							
10	Administrative and Clerical	287,256	14,347	1,193,301	1,494,904	(455)	1,494,449	10
11	Marketing Materials, Promotions and Advertising	108,915		96,456	205,371		205,371	11
12	Employee Benefits and Payroll Taxes			221,679	221,679		221,679	12
13	Insurance-Property, Liability and Malpractice			57,226	57,226		57,226	13
14	Other (specify): Service Provider Fees			224,983	224,983		224,983	14
15	<b>TOTAL General Administration</b>	396,171	14,347	1,793,645	2,204,163	(455)	2,203,708	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	1,282,844	409,642	2,072,079	3,764,565	(6,972)	3,757,593	16
	<b>Capital Expenses</b>							
	<b>D. Ownership</b>							
17	Depreciation			544,316	544,316	(57,775)	486,541	17
18	Interest			227,831	227,831	(4,640)	223,191	18
19	Real Estate Taxes			176,475	176,475		176,475	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			19,358	19,358		19,358	21
22	Other (specify): Mortgage Insurance			46,646	46,646		46,646	22
23	<b>TOTAL Ownership</b>			1,014,626	1,014,626	(62,415)	952,211	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	1,282,844	409,642	3,086,705	4,779,191	(69,387)	4,709,804	24

Facility Name: THE POINTE AT KILPATRICK

Report Period Beginning 01/01/2015 Ending: 12/31/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 28.03	1
2	Licensed Practical Nurses	2	23.78	2
3	Certified Nurse Assistants	13	10.46	3
4	Activity Director & Assistants	2	14.42	4
5	Social Service Workers			5
6	Head Cook	2	13.64	6
7	Cook Helpers/Assistants	7	8.62	7
8	Dishwashers			8
9	Maintenance Workers	1	24.03	9
10	Housekeepers	3	11.37	10
11	Laundry			11
12	Managers	1	47.43	12
13	Other Administrative	3	24.69	13
14	Clerical	2	12.79	14
15	Marketing	2	29.53	15
16	Other Director of Nursing	1	44.16	16
17	Total (lines 1 thru 16)	41	\$ 14.97	17

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, LLC	MORRIS

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5

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).

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
Total				\$	6

VI. (B) Management fees paid to unrelated parties Amount of Fee

1		\$	1
2			2
Total		\$	3

Facility Name: THE POINTE AT KILPATRICK

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

**VIII. OWNERSHIP COSTS**

A. Purchase price of land 350,000 Year land was acquired 2003

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

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

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	122			2003	\$ 12,408,081	\$ 451,203	27.5	\$ 451,203	\$	\$ 5,403,146	1
2				2003	438,754	25,846	15	29,250	3,404	353,440	2
3				2003	300,000	10,909	27.5	10,909		112,273	3
4											4
5											5
	<b>Improvement Type</b>										
6	REMODEL NURSES' STATION, KITCHEN &										6
7	DINING AREA & RECEPTIONAL DESK			2013	46,000	1,673	27.5	1,673		4,670	7
8	REPLACE WALKS ON NORTHSIDE OF BUILDING										8
9	AND INSTALL ADA PLACARD			2014	7,850	285	27.5	285		380	9
10	ROOF SHINGLE AND FASCIA REPAIRS			2014	7,000	255	27.5	255		319	10
11	REMODELING SAMPLE SHARED SUITE #216 A & B,										11
12	1 AND 3RD SAMPLE BEDROOM #219 & #308			2015	58,058	1,056	27.5	1,056		1,056	12
13	BEDROOM UNITS #221,309 & 319 INTERIOR										13
14	RENOVATION			2015	76,554	5,675	5	5,675		5,675	14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 13,342,297	\$ 496,902		\$ 500,306	\$ 3,404	\$ 5,880,959	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 1,037,762	\$ 47,414	\$ 108,680	61,266	3-10	\$ 532,653	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 1,037,762	\$ 47,414	\$ 108,680	61,266		\$ 532,653	20

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

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

Facility Name: THE POINTE AT KILPATRICK

Report Period Beginning: 01/01/2015 Ending: 2/31/2015

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				\$			7

8. Is movable equipment rental included in building rental?  
YES NO

9. Rental amount for movable equipment \$

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	2		3	4	6		7	8	9	
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1	PR MORTGAGE & INVEST		X	MORTGAGE	12/1/02	\$ 10,000,000	\$ 9,258,486	1/1/53	2.4200	\$ 225,753	1
2	LOAN COST		X		12/5/03	123,675	116,874	/ /		2,078	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 10,123,675	\$ 9,375,360			\$ 227,831	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 10,123,675	\$ 9,375,360			\$ 227,831	10

\* If there is an option to buy the building, please provide complete details on an attached schedule.  
\*\* If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: THE POINTE AT KILPATRICK

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,383,959	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 22,177 )	690,454		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	93,520		6
7	Other Prepaid Expenses	75,348		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>ESCROW DEPOSITS</b>	1,094,316		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,337,597	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	350,000		13
14	Buildings, at Historical Cost	13,342,297		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,037,762		16
17	Accumulated Depreciation (book methods)	(6,868,247)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (LOAN FEES	83,874		22
23	Other(specify): <b>SYNDICATION COSTS</b>	33,000		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 7,978,686	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 11,316,283	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 284,530	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	298,316		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,870		30
31	Accrued Taxes Payable	142,679		31
32	Accrued Interest Payable	18,671		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36				36
37	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 36)	\$ 764,066	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	9,258,486		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</b> (sum of lines 38 thru 43)	\$ 9,258,486	\$	44
45	<b>TOTAL LIABILITIES</b> (sum of lines 37 and 44)	\$ 10,022,552	\$	45
46	<b>TOTAL EQUITY</b>	\$ 1,293,731	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 45 and 46)	\$ 11,316,283	\$	47

\*(See instructions.)

Facility Name: THE POINTE AT KILPATRICK

Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Revenue	Amount	
	<b>A. SLF Resident Care</b>		
1	Gross SLF Resident Revenue	\$ 4,434,501	1
2	Discounts and Allowances	(22,177)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	\$ 4,412,324	3
	<b>B. Other Operating Revenue</b>		
4	Special Services		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	320	10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	\$ 320	11
	<b>C. Non-Operating Revenue</b>		
12	Contributions		12
13	Interest and Other Investment Income	4,640	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	\$ 4,640	14
	<b>D. Other Revenue (specify):</b>		
15	VENDING COMMISSION	525	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	\$ 525	17
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	\$ 4,417,809	18

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
19	General Services	1,001,695	19
20	Health Care/ Personal Care	558,707	20
21	General Administration	2,204,163	21
	<b>B. Capital Expense</b>		
22	Ownership	1,014,626	22
	<b>C. Other Expenses</b>		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	\$ 4,779,191	28
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	\$ (361,382)	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	\$ (361,382)	31



DESCRIPTION	AMOUNT
SALES TAX ON FOOD	(1,916)
CABLE TV - RESIDENT ROOMS	(4,601)
PENALTIES	(455)
STRAIGHT LINE DEPRECIATION	(57,775)
INTEREST INCOME	(4,640)
TOTAL ADJUSTMENT	(69,387)