FOR BHF USE

LL2

Supportive Living Facility

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)

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 (Number) CRESTWOOD (City) 60445 (Zip Code)

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:

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

In the event there are further questions about this report, please contact:
Name: **Telephone Number:** ( )
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 01/01/2017 to 12/31/2017 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

2017

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
(Title) MANAGER

Paid Preparer

(Signed) (Date)
(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: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	9,450	5,141		14,591	5
6	Double Unit	15,718	8,463		24,181	6
7	Other					7
8	TOTALS	25,168	13,604		38,772	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 87.07%

D. Indicate the number of paid bed-hold days the SLF had during this year 744 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 1090 **(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: 2017 Fiscal Year: 2017
* 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.

Facility Name: THE POINTE AT KILPATRICK **Report Period Beginning: 01/01/2017 Ending: 12/31/2017**

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

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	315,196	365,195	11,553	691,944	(2,140)	689,804	1
2	Housekeeping, Laundry and Maintenance	134,085	98,090	55,389	287,564		287,564	2
3	Heat and Other Utilities			134,578	134,578	(5,589)	128,989	3
4	Other (specify): Scavenger & Exterminating Services			11,490	11,490		11,490	4
5	**TOTAL General Services**	449,281	463,285	213,010	1,125,576	(7,729)	1,117,847	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	741,743	7,999		749,742		749,742	6
7	Activities and Social Services	81,199	22,865		104,064		104,064	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	822,942	30,864		853,806		853,806	9
	C. General Administration							
10	Administrative and Clerical	317,900	27,344	561,429	906,673		906,673	10
11	Marketing Materials, Promotions and Advertising	192,144		45,993	238,137		238,137	11
12	Employee Benefits and Payroll Taxes			314,821	314,821		314,821	12
13	Insurance-Property, Liability and Malpractice			75,490	75,490		75,490	13
14	Other (specify): Service Provider Fees			300,146	300,146		300,146	14
15	**TOTAL General Administration**	510,044	27,344	1,297,879	1,835,267		1,835,267	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,782,267	521,493	1,510,889	3,814,649	(7,729)	3,806,920	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			535,685	535,685	(79,101)	456,584	17
18	Interest			221,338	221,338	(1,763)	219,575	18
19	Real Estate Taxes			143,352	143,352		143,352	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			14,765	14,765		14,765	21
22	Other (specify):Mortgage Insurance			45,083	45,083		45,083	22
23	**TOTAL Ownership**			960,223	960,223	(80,864)	879,359	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,782,267	521,493	2,471,112	4,774,872	(88,593)	4,686,279	24

Facility Name: THE POINTE AT KILPATRICK **Report Period Beginning: 01/01/2017 Ending: 12/31/2017**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	$ 28.50	1
2	Licensed Practical Nurses	2	26.30	2
3	Certified Nurse Assistants	14	11.72	3
4	Activity Director & Assistants	2	18.47	4
5	Social Service Workers			5
6	Head Cook	3	11.38	6
7	Cook Helpers/Assistants	6	10.20	7
8	Dishwashers			8
9	Maintenance Workers	2	14.04	9
10	Housekeepers	3	10.58	10
11	Laundry			11
12	Managers	4	25.24	12
13	Other Administrative	3	40.78	13
14	Clerical	3	13.38	14
15	Marketing	2	34.34	15
16	Other **Director of Nursing**	1	40.87	16
17	**Total (lines 1 thru 16)**	47	$ 16.39	17

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
			2017	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1		$	1
2			2
	Total	$	3

VII. RELATED ORGANIZATIONS

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

RELATED SLF's & HEALTH CARE BUSINESSES		OTHER RELATED BUSINESS ENTITIES		
Name 1	City 2	Name 3	City 4	Type of Business 5
PARK POINT SUPPORTIVE LIVING	MORRIS			
PONTIAC SUPPORTIVE LIVING	PONTIAC			
CRYSTAL CREEK SUPPORTIVE LIVING	CANTON MI			

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** [X]

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** [X]

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: THE POINTE AT KILPATRICK Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 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				2003	$ 12,408,081	$ 451,203	27.5	$ 451,203	$	$ 6,305,552	1
2				2003	438,754	15,955	15	15,955		385,739	2
3				2003	300,000	10,909	27.5	10,909		134,091	3
4											4
5											5
	Improvement Type										
6	REMODEL NURSES' STATION, KITCHEN &										6
7	DINING AREA & RECEPTIONAL DESK			2013	46,000	1,673	27.5	1,673		7,528	7
8	REPLACE WALKS ON NORTHSIDE OF BUILDING										8
9	AND INSTALL ADA PLACARD			2014	7,850	285	27.5	285		867	9
10	ROOF SHINGLE AND FASCIA REPAIRS			2014	7,000	255	27.5	255		755	10
11	REMODELING SAMPLE SHARED SUITE #216 A & B,										11
12	1 AND 3RD SAMPLE BEDROOM #219 & #308			2015	58,058	2,110	27.5 #	2,110	##	5,276	12
13	BEDROOM UNITS #221,309 & 319 INTERIOR										13
14	RENOVATION			2015	76,554	2,785	27.5	2,785		11,245	14
15	BEDROOM UNITS #104,106,119,121,124,125,126,128,										15
16	208209301302304 INTERIOR RENOVATION			2016	233,240	8,483	27.5	8,483		13,535	16
17	TOTAL (lines 1 thru 16)				$ 13,575,537	$ 493,658		$ 493,658	$	$ 6,864,588	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	$ 1,139,838	$ 38,698	$ 117,799	79,101	3-10	$ 761,981	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 1,139,838	$ 38,698	$ 117,799	79,101		$ 761,981	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: 01/01/2017 12/31/2017

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 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						$	$		$	$	$	1
2												2
3												3
4												4
5												5
	Improvement Type											
6	BEDROOM UNITS # 120,122,127,205,213,223											6
7	208209301302304 INTERIOR RENOVATION				2017	113,657	3,329	27.5	3,329		3,329	7
8												8
9												9
10												10
11												11
12										###		12
13												13
14												14
15												15
16												16
17	TOTAL (lines 1 thru 16)					$ 113,657	$ 3,329		$ 3,329	$	$ 3,329	17

C. Equipment Depreciation -- Including Transportation.

	Type	Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	6 Accumulated Depreciation	
18	Movable Equipment		$	$	$	18
19	Vehicles					19
20	TOTAL (lines 18 and 19) 0	0	$ 0		$	20

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

	1 Description and Year Acquired	2 Cost	3 Current E Depreci	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:** 01/01/2017 **Ending:** 2/31/2017

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 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 2017 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	#
	A. Directly Facility Related										
	Long-Term										
1	PR MORTGAGE & INVEST	X		MORTGAGE	12/1/02	$ 10,000,000	$ 8,942,397	1/1/53	2.4200	$ 218,188	1
2	LOAN COST	X			12/5/03	123,675	107,801	/ /		3,150	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 10,123,675	$ 9,050,198			$ 221,338	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 10,123,675	$ 9,050,198			$ 221,338	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:** 01/01/2017 **Ending:** 12/31/2017

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,109,422	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	504,987		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,307		6
7	Other Prepaid Expenses	88,259		7
8	Accounts Receivable (owners or related parties)	60,400		8
9	Other(specify): ESCROW DEPOSITS	465,729		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,323,104	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	350,000		13
14	Buildings, at Historical Cost	13,689,193		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,135,913		16
17	Accumulated Depreciation (book methods)	(7,915,898)		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**	74,801		22
23	Other(specify): SYNDICATIONAL COSTS	33,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,367,009	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,690,113	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 61,309	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	167,188		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,929		30
31	Accrued Taxes Payable	150,125		31
32	Accrued Interest Payable	18,034		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	PREPAID REVENUE	520,477		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 2,017	$	###
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,942,397		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 8,942,397	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 8,944,414	$	45
46	**TOTAL EQUITY**	$ (224,346)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 8,720,068	$	47

***(See instructions.)**

Facility Name: THE POINTE AT KILPATRICK **Report Period Beginning: 01/01/2017 Ending: 12/31/2017**

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 4,833,451	1
2	Discounts and Allowances	(137,477)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 4,695,974	3
	B. Other Operating Revenue		
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	150	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 150	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	1,763	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 1,763	14
	D. Other Revenue (specify):		
15	**VENDING COMMISSIONS**	357	15
16	**COMMUNITY & APPLICATIONA FEES**	57,990	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 58,347	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 4,756,234	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	1,125,576	19
20	Health Care/ Personal Care	853,806	20
21	General Administration	1,835,267	21
	B. Capital Expense		
22	Ownership	960,223	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	**TOTAL EXPENSES (sum of lines 19 thru 27)**	$ 4,774,872	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (18,638)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (18,638)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 2,652,530	32
33	Private Pay - Net Inpatient Revenue	2,180,921	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 4,833,451	37

DESCRIPTION	AMOUNT
SALES TAX ON FOOD	(2,140)
CABLE TV - RESIDENT ROOMS	(5,589)
STRAIGHT LINE DEPRECIATION	(79,101)
INTEREST INCOME	(1,763)
TOTAL ADJUSTMENT	(88,593)