

		FOR BHF USE			

LL2

Supportive Living Facility

2018

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2018)

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: 1000109

Facility Name: PARK POINT SUPPORTIVE LIVING

Address: 1221 SOUTH EDGEWATER MORRIS 60450

Number City Zip Code

County: GRUNDY

Telephone Number: ( 815 ) 416-6200 Fax # ( 815 ) 416-6201

Federal Employer ID Number: \_\_\_\_\_

Date Current Owners were Certified: 06/27/2013

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 type="checkbox"/>	_____
		<input checked="" type="checkbox"/>	Limited Liability Co.	<input type="checkbox"/>	_____
		<input type="checkbox"/>	Trust	<input type="checkbox"/>	_____
		<input type="checkbox"/>	Other	<input type="checkbox"/>	_____

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

Name: KATHLEEN MCNAMARA 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 01/01/2018 to 12/31/2018 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

(Title) MANAGER

Paid  
Preparer

(Signed) \_\_\_\_\_ (SEE ATTACHED ACCOUNTANTS' REPORT)  
(Date) \_\_\_\_\_

(Print Name and Title) KATHLEEN MCNAMARA  
VICE-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** **PARK POINT SUPPORTIVE LIVING**

Report Period Beginning: 01/01/2018 Ending: 12/31/2018

### III. STATISTICAL DATA

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

### Date of change in certified units

1 / 1

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	40	Single Unit Apartment	40	14,600	1		
2	18	Double Unit Apartment	18	6,570	2		
3		Other			3		
4	58	TOTALS	58	21,170	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	6,211	11,119		17,330	5
6	Double Unit		2,555		2,555	6
7	Other					7
8	TOTALS	6,211	13,674		19,885	8

**C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.)** 93.93%

**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** ☒

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

YES ☐ NO ☒

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

## H. ACCOUNTING BASIS

ACCUAL		MODIFIED	
		CASH*	CASH*
	X		

**I. Is your fiscal year identical to your tax year?** ☒ YES ☐ NO

**Tax Year:** \_\_\_\_\_ **Fiscal Year:** \_\_\_\_\_

\* 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 principal? \_\_\_\_\_**  
**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 principal?** \_\_\_\_\_  
**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 principal? \_\_\_\_\_**  
**If no, explain.**

## STATE OF ILLINOIS

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Facility Name: PARK POINT SUPPORTIVE LIVING

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

## 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	182,700	160,047	6,801	349,548		349,548	1
2	Housekeeping, Laundry and Maintenance	75,182	64,952	78,373	218,507		218,507	2
3	Heat and Other Utilities			59,042	59,042		59,042	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	257,882	224,999	144,216	627,097		627,097	5
	<b>B. Health Care and Programs</b>							
6	Health Care/ Personal Care	295,730	4,878	15,810	316,418		316,418	6
7	Activities and Social Services	23,890	41,174		65,064		65,064	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	319,620	46,052	15,810	381,482		381,482	9
	<b>C. General Administration</b>							
10	Administrative and Clerical	308,211	18,921	219,716	546,848	9,400	556,248	10
11	Marketing Materials, Promotions and Advertising			51,216	51,216		51,216	11
12	Employee Benefits and Payroll Taxes			125,605	125,605		125,605	12
13	Insurance-Property, Liability and Malpractice			17,550	17,550	18,539	36,089	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	308,211	18,921	414,087	741,219	27,939	769,158	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	885,713	289,972	574,113	1,749,798	27,939	1,777,737	16
	<b>Capital Expenses</b>							
	<b>D. Ownership</b>							
17	Depreciation			6,955	6,955	111,348	118,303	17
18	Interest					240,523	240,523	18
19	Real Estate Taxes					77,099	77,099	19
20	Rent -- Facility and Grounds			616,837	616,837	(616,837)		20
21	Rent -- Equipment			7,890	7,890		7,890	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			631,682	631,682	(187,867)	443,815	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	885,713	289,972	1,205,795	2,381,480	(159,928)	2,221,552	24

Facility Name: PARK POINT SUPPORTIVE LIVING

Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.5	\$ 28.05	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	8.0	12.32	3
4	Activity Director & Assistants	1.0	12.78	4
5	Social Service Workers			5
6	Head Cook	1.0	20.50	6
7	Cook Helpers/Assistants	6.5	10.75	7
8	Dishwashers			8
9	Maintenance Workers	1.0	18.25	9
10	Housekeepers	1.5	9.00	10
11	Laundry			11
12	Managers	1.0	37.00	12
13	Other Administrative			13
14	Clerical	1.0	17.00	14
15	Marketing	1.0	26.00	15
16	Other			16
17	Total (lines 1 thru 16)	23.5	\$	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
THE POINTE AT KILPATRICK	CRESTWOOD
PONTIAC SUPPORTIVE LIVING	PONTIAC
CRYSTAL CREEK	MICHIGAN

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	NA			\$	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

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
MORRIS REAL ESTATE	MORRIS	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: PARK POINT SUPPORTIVE LIVING

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

## VIII. OWNERSHIP COSTS

A. Purchase price of land 100,000 Year land was acquired 2013

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	58		2013	2009	\$ 2,674,498	\$	39	\$ 68,577	\$ 68,577	\$ 382,888	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	REROUTE GAS LINE			2014	8,799		39	225	225	977	6
7	ROOF NET OF INSURANCE			2014	35,130		39	901	901	3,914	7
8	LANDSCAPING			2015	10,204		15	680	680	2,380	8
9				2015	7,417		39	190	190	610	9
10	AC UNITS			2017	5,540		39	142	142	284	10
11	PLUMBING WORK			2017	16,175		39	415	415	830	11
12	FLOORING			2017	27,038		39	693	693	1,386	12
13	AIR CONDITIONING			2018	17,495		39	449	449	449	13
14	FLOORING			2018	24,149		39	619	619	619	14
15	LANDSCAPING			2018	31,878		39	817	817	817	15
16						118,303			(118,303)		16
17	TOTAL (lines 1 thru 16)				\$ 2,858,323	\$ 118,303		\$ 73,708	\$ (44,595)	\$ 395,154	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	\$ 423,184	\$	\$ 42,318	42,318	10	\$ 234,439	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 423,184	\$	\$ 42,318	42,318		\$ 234,439	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: PARK POINT SUPPORTIVE LIVING

Report Period Beginning: 01/01/2018 Ending: 2/31/2018

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: NA

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

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	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	CAMBRIDGE		X	MORTGAGE	7/1/14	\$ 6,560,000	\$ 6,135,764	/ /	3.8900	\$ 240,523	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 6,560,000	\$ 6,135,764			\$ 240,523	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 6,560,000	\$ 6,135,764			\$ 240,523	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: **PARK POINT SUPPORTIVE LIVING**Report Period Beginning: **01/01/2018**Ending: **12/31/2018****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2018**

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 170,202	\$ 172,889	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	236,945	236,945	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,710	40,917	6
7	Other Prepaid Expenses	35,780	35,780	7
8	Accounts Receivable (owners or related parties)	605,000	605,000	8
9	Other(specify):		156,145	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,054,637	\$ 1,247,676	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		2,831,286	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,955	423,184	16
17	Accumulated Depreciation (book methods)	(6,955)	(747,779)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		133,882	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(17,211)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <b>GOODWILL NET</b>		2,606,485	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 5,329,847	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,054,637	\$ 6,577,523	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	67,165	67,165	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,090	33,090	30
31	Accrued Taxes Payable	3,185	80,718	31
32	Accrued Interest Payable		19,891	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 (sum of lines 26 thru 36)</b>	\$ 103,440	\$ 200,864	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable		6,135,764	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>	\$	\$ 6,135,764	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 103,440	\$ 6,336,628	45
46	<b>TOTAL EQUITY</b>	\$ 951,197	\$ 240,895	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 1,054,637	\$ 6,577,523	47

\*(See instructions.)

Facility Name: PARK POINT SUPPORTIVE LIVING

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

**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	\$ 2,718,705	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	\$ 2,718,705	3
	<b>B. Other Operating Revenue</b>		
4	Special Services	27,515	4
5	Other Health Care Services	25,119	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>	\$ 52,634	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>	\$	14
	<b>D. Other Revenue (specify):</b>		
15			15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	\$	17
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	\$ 2,771,339	18

2			
	II. Expenses	Amount	
	<b>A. Operating Expenses</b>		
19	General Services	627,097	19
20	Health Care/ Personal Care	381,482	20
21	General Administration	741,219	21
	<b>B. Capital Expense</b>		
22	Ownership	631,682	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>	\$ 2,381,480	28
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	\$ 389,859	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	\$ 389,859	31
	<b>III. Net Resident Care Revenue detailed by Payer Source</b>		
32	Medicaid - Net Inpatient Revenue	\$ 648,655	32
33	Private Pay - Net Inpatient Revenue	2,070,050	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>	\$ 2,718,705	37



2018

	LINE	
RENT	20	(616,837)
PROFESSIONAL FEES	10	9,400
INSURANCE	13	18,539
DEPRECIATION	17	111,348
INTEREST	18	240,523
RE TAX	19	77,099
		<u>(159,928)</u>
		<u><u>(159,928)</u></u>