

		FOR BHF USE			

LL2

Supportive Living Facility

2019

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2019)

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

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:

☐ VOLUNTARY, NON-PROFIT Charitable Corp.
☐ Trust
 IRS Exemption Code _____

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other _____

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other _____

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 1/1/2019 to 12/31/2019 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.
8410 RIVER DR., 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

HFS 3745C (N-4-05)

IL478-2471

Facility Name **PARK POINT SUPPORTIVE LIVING**

Report Period Beginning: 1/1/2019 Ending: 12/31/2019

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	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	7,577	9,400		16,977	5
6	Double Unit		2,555		2,555	6
7	Other					7
8	TOTALS	7,577	11,955		19,532	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.26%

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:

1/1/2019

Ending: 12/31/2019

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			
	A. General Services							
1	Dietary and Food Purchase	191,496	183,406	10,469	385,371		385,371	1
2	Housekeeping, Laundry and Maintenance	76,251	75,817	70,119	222,187	16,535	238,722	2
3	Heat and Other Utilities			66,113	66,113	(9,905)	56,208	3
4	Other (specify):			4,730	4,730		4,730	4
5	TOTAL General Services	267,747	259,223	151,431	678,401	6,630	685,031	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	360,789	2,600		363,389		363,389	6
7	Activities and Social Services	25,223	46,488		71,711		71,711	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	386,012	49,088		435,100		435,100	9
	C. General Administration							
10	Administrative and Clerical	203,535	27,270	187,592	418,397	8,400	426,797	10
11	Marketing Materials, Promotions and Advertising			33,207	33,207		33,207	11
12	Employee Benefits and Payroll Taxes			111,869	111,869		111,869	12
13	Insurance-Property, Liability and Malpractice			25,041	25,041	16,401	41,442	13
14	Other (specify):							14
15	TOTAL General Administration	203,535	27,270	357,709	588,514	24,801	613,315	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	857,294	335,581	509,140	1,702,015	31,431	1,733,446	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					114,052	114,052	17
18	Interest			690	690	226,448	227,138	18
19	Real Estate Taxes					79,251	79,251	19
20	Rent -- Facility and Grounds			557,837	557,837	(557,837)		20
21	Rent -- Equipment			24,024	24,024		24,024	21
22	Other (specify): Mortgage Insurance					39,506	39,506	22
23	TOTAL Ownership			582,551	582,551	(98,580)	483,971	23
24	GRAND TOTAL (Sum of lines 16 and 23)	857,294	335,581	1,091,691	2,284,566	(67,149)	2,217,417	24

Facility Name: PARK POINT SUPPORTIVE LIVING

Report Period Beginning 1/1/2019 Ending: 12/31/2019

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 25.67	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6	13.34	3
4	Activity Director & Assistants	1	12.10	4
5	Social Service Workers			5
6	Head Cook	1	21.56	6
7	Cook Helpers/Assistants	3	10.31	7
8	Dishwashers			8
9	Maintenance Workers	1	18.18	9
10	Housekeepers	2	10.08	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	48.08	13
14	Clerical	1	17.20	14
15	Marketing	1	31.47	15
16	Other			16
17	Total (lines 1 thru 16)	19	\$ 15.93	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 ASSISTANT LIVING	CANTON, MI
THE POINTE AT JACKSONVILLE,LLC	JACKSONVILLE

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? \$

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

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
MORRIS REAL ESTATE	MORRIS	PROPCO

Facility Name: PARK POINT SUPPORTIVE LIVING

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

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	58		2013	2009	\$ 2,674,498	\$ 68,577	39	\$ 68,577		\$ 451,465	1
2											2
3											3
4											4
5											5
	Improvement Type										
6		REROUTE GAS LINE		2014	8,799	225	39	225		1,202	6
7		ROOF NET OF INSURANCE		2014	35,130	901	39	901		4,815	7
8		LANDSCAPING		2015	10,204	680	15	680		3,060	8
9				2015	7,417	190	39	190		800	9
10		AC UNITS		2017	5,540	142	39	142		426	10
11		PLUMBING WORK		2017	16,175	415	39	415		1,245	11
12		FLOORING		2017	27,038	693	39	693		2,079	12
13		AIR CONDITIONING		2018	17,495	449	39	449		898	13
14		FLOORING		2018	24,149	619	39	619		1,238	14
15		LANDSCAPING		2018	31,878	2,125	15	2,125		2,942	15
16		FLOORING		2019	30,752	362	39	362		362	16
17	TOTAL (lines 1 thru 16)				\$ 2,889,075	\$ 75,378		\$ 75,378		\$ 470,532	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	\$ 428,123	\$ 40,743	\$ 42,812	2,069	10	\$ 277,251	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 428,123	\$ 40,743	\$ 42,812	2,069		\$ 277,251	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: 1/1/2019 Ending: 2/31/2019

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	\$ 6,029,181	/ /	3.8900	\$ 236,448	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 6,560,000	\$ 6,029,181			\$ 236,448	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 6,560,000	\$ 6,029,181			\$ 236,448	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.

STATE OF ILLINOIS

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Facility Name: **PARK POINT SUPPORTIVE LIVING**Report Period Beginning: **1/1/2019**Ending: **12/31/2019****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2019**

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 58,486	\$ 60,831	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	250,100	250,100	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		29,005	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	505,000	505,000	8
9	Other(specify): ESCROWS		177,574	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 813,586	\$ 1,022,510	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		2,674,498	14
15	Leasehold Improvements, at Historical Cost		214,578	15
16	Equipment, at Historical Cost	6,955	428,123	16
17	Accumulated Depreciation (book methods)	(6,955)	(861,370)	17
18	Deferred Charge Deferred Loan Costs-Net		112,847	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): GOODWILL NET		2,327,218	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 4,995,894	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 813,586	\$ 6,018,404	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,502	\$ 2,502	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	75,236	75,236	28
29	Short-Term Notes Payable	50,000	50,000	29
30	Accrued Salaries Payable	40,426	40,426	30
31	Accrued Taxes Payable	3,830	82,998	31
32	Accrued Interest Payable		19,545	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 171,994	\$ 270,707	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		6,029,181	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)	\$	\$ 6,029,181	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 171,994	\$ 6,299,888	45
46	TOTAL EQUITY	\$ 641,592	\$ (281,484)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 813,586	\$ 6,018,404	47

*(See instructions.)

Facility Name: PARK POINT SUPPORTIVE LIVING

Report Period Beginning: 1/1/2019

Ending:

12/31/2019

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

		1	
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,778,613	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,778,613	3
	B. Other Operating Revenue		
4	Special Services	26,230	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	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 26,230	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	10,000	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 10,000	14
	D. Other Revenue (specify):		
15	PRIOR YEAR ADJUSTMENT	(272,212)	15
16	FOOD STAMP	13,278	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ (258,934)	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,555,909	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	678,401	19
20	Health Care/ Personal Care	435,100	20
21	General Administration	588,514	21
	B. Capital Expense		
22	Ownership	582,551	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27	REBILLED SALARIES	144,000	27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 2,428,566	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 127,343	29
30	Income Taxes	\$ 1,949	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 125,394	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,946,024	32
33	Private Pay - Net Inpatient Revenue	832,589	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,778,613	37

IMN 5 NOT ALLOWABLE EXPENSES

CABLE TV-RESIDENT ROOMS	(9,905)
POLITICAL CONTRIBUTIONS	(1,000)
STRAIGHT LINE DEPRECIATION	(2,069)
INTEREST INCOME	(10,000)

RTY LANDLORD

RENT	(557,837)
GROUND MAINTENANCE	16,535
PROFESSIONAL FEES	9,400
INSURANCE-PROPERTY	16,401
DEPRECIATION	116,121
MORTGAGE INTEREST	236,448
REAL ESTATE TAXES	79,251
MORTGAGE INSURANCE	39,506

GRAND TOTAL	(67,149)
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