

		FOR BHF USE			

LL2

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.

I. Facility ID Number: 1000037

Facility Name: POINTE AT JACKSONVILLE

Address: 20 JACKSONVILLE PL JACKSONVILLE 62650

County: MORGAN

Telephone Number: (217) 245-5101 Fax # (217) 245-2000

Federal Employer ID Number: _____

Date Current Owners were Certified: 10/1/2019

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT Charitable Corp.
☐ Trust

☒ PROPRIETARY

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

☐ GOVERNMENTAL

☐ State
☐ County
☐ Other

IRS Exemption Code _____

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 1/1/2020 to 12/31/2020 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. 6201 W. HOWARD ST., SUITE 201 NILES IL 60714

(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 **POINTE AT JACKSONVILLE****Report Period Beginning: 1/1/2020 Ending: 12/31/2020**

III. STATISTICAL DATA

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

Date of change in certified units

11 / 11

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	82	Single Unit Apartment	82	30,012	1		
2	4	Double Unit Apartment	4	1,464	2		
3		Other			3		
4	86	TOTALS	86	31,476	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	12,842	8,695		21,537	5
6	Double Unit					6
7	Other					7
8	TOTALS	12,842	8,695		21,537	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) **68.42%**

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 ☐ **X**

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: 2020 **Fiscal Year:** 2020

* 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: 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 and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
	A. General Services							
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	TOTAL General Services	411,503	314,302	274,236	1,000,041	(48,141)	951,900	5
	B. Health Care and Programs							
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	TOTAL Health Care and Programs	413,318	106,787	18	520,123		520,123	9
	C. General Administration							
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	TOTAL General Administration	165,616	23,001	421,172	609,789	14,006	623,795	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	990,437	444,090	695,426	2,129,953	(34,135)	2,095,818	16
	Capital Expenses							
	D. Ownership							
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	TOTAL Ownership			609,050	609,050	132,745	741,795	23
24	GRAND TOTAL (Sum of lines 16 and 23)	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	Total (lines 1 thru 16)	27	\$ 14.51	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	MORRIS
PONTIAC SUPPORTIVE LIVING	PONTIAC
CRYSTAL CREEK ASSISTANT LIVING	CANTON MI
THE POINTE AT KILPATRICK	CRESTWOOD

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

OTHER RELATED BUSINESS ENTITIES		
Name 3	City 4	Type of Business 5
JACKSONVILLE LANDLORD LLC	JACKSONVILLE	PROPCO

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 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	86		2019		7,878,418	286,488	27.5	286,488		322,299	2
3											3
4											4
5											5
	Improvement Type										
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 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated 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 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: POINTE AT JACKSONVILLE

Report Period Beginning: 1/1/2020

Ending: 2/31/2020

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	GERSHMAN INVESTMENT				/ /	\$		/ /		\$	1
2	GROUP		X	MORTGAGE	9/1/20	6,811,898	6,786,319	3/1/56	3.2600	273,328	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 6,811,898	\$ 6,786,319			\$ 273,328	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 6,811,898	\$ 6,786,319			\$ 273,328	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: 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 Operating	2 After Consolidation*	
	A. Current Assets			
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): ESCROWS		330,736	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,648,522	\$ 2,075,526	10
	B. Long-Term Assets			
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 Deferred Loan Costs-Net		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): Deposit on Fixed Assets		3,840	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 8,248,226	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,648,522	\$ 10,323,752	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
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
	Other Current Liabilities(specify):			
35	SBA PPP LOAN	235,500	235,500	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,187,242	\$ 1,423,860	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		6,681,897	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)	\$	\$ 6,681,897	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,187,242	\$ 8,105,757	45
46	TOTAL EQUITY	\$ 461,280	\$ 2,217,995	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 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	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,524,546	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,524,546	3
	B. Other Operating Revenue		
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	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 1,340	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
	D. Other Revenue (specify):		
15	FOOD STAMP INCOME	54,306	15
16	STIMULUS PAYMENT	137,713	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 192,019	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,717,905	18

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