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: 1000109

Facility Name: PARK POINT SUPPORTIVE LIVING

Address: 1221 SOUTH EDGEWATER (Number) MORRIS (City) 60450 (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:

	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: 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
(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 T(0
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: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	7,279	12,187		19,466	5
6	Double Unit		1,100		1,100	6
7	Other					7
8	TOTALS	7,279	13,287		20,566	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.15%

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: _____ 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 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: PARK POINT SUPPORTIVE LIVING **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	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	**174,618**	**160,614**	**3,965**	**339,197**		**339,197**	1
2	Housekeeping, Laundry and Maintenance	**70,157**	**80,224**	**51,254**	**201,635**		**201,635**	2
3	Heat and Other Utilities			**53,653**	**53,653**		**53,653**	3
4	Other (specify):							4
5	**TOTAL General Services**	**244,775**	**240,838**	**108,872**	**594,485**		**594,485**	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	**305,207**	**5,450**		**310,657**		**310,657**	6
7	Activities and Social Services	**21,539**	**25,839**		**47,378**		**47,378**	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	**326,746**	**31,289**		**358,035**		**358,035**	9
	C. General Administration							
10	Administrative and Clerical	**83,407**	**16,072**	**76,092**	**175,571**		**175,571**	10
11	Marketing Materials, Promotions and Advertising	**12,452**	**9,658**	**13,531**	**35,641**		**35,641**	11
12	Employee Benefits and Payroll Taxes			**72,948**	**72,948**		**72,948**	12
13	Insurance-Property, Liability and Malpractice			**68,036**	**68,036**		**68,036**	13
14	Other (specify):							14
15	**TOTAL General Administration**	**95,859**	**25,730**	**230,607**	**352,196**		**352,196**	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	**667,380**	**297,857**	**339,479**	**1,304,716**		**1,304,716**	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					**140,644**	**140,644**	17
18	Interest			**88**	**88**	**251,834**	**251,922**	18
19	Real Estate Taxes					**75,056**	**75,056**	19
20	Rent -- Facility and Grounds			**521,237**	**521,237**	**(521,237)**		20
21	Rent -- Equipment							21
22	Other (specify): CONSULTING FEES			**90,000**	**90,000**		**90,000**	22
23	**TOTAL Ownership**			**611,325**	**611,325**	**(53,703)**	**557,622**	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	**667,380**	**297,857**	**950,804**	**1,916,041**	**(53,703)**	**1,862,338**	24

Facility Name: PARK POINT SUPPORTIVE LIVING 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	$ 24.25	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	8	10.58	3
4	Activity Director & Assistants	1	10.50	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	8	10.63	7
8	Dishwashers			8
9	Maintenance Workers	2	8.50	9
10	Housekeepers	2	8.50	10
11	Laundry			11
12	Managers	1	30.00	12
13	Other Administrative			13
14	Clerical	2	12.59	14
15	Marketing	1	23.00	15
16	Other			16
17	Total (lines 1 thru 16)	26	$	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	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

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
THE POINT AT KILPATRICK	CRESTWOOD	NA		
CRYSTAL CREEK SUPPORTIVE LIVIN(	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: NA 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 [X] 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: 01/01/2015 Ending: 12/31/2015

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	$ 68,577	39	$ 68,577	$	$ 177,157	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	REROUTE GAS LINE			2014	8,799	225	39	225		302	6
7	ROOF NET OF INSURANCE			2014	35,130	901	39	901		1,211	7
8	LANDSCAPING			2015	10,204	340	15	340		340	8
9				2015	7,417	40	39	40		40	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 2,736,048	$ 70,083		$ 70,083	$	$ 179,050	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	$ 398,472	$ 70,561	$ 39,847	(30,714)	10	$ 108,875	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 398,472	$ 70,561	$ 39,847	(30,714)		$ 108,875	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:** 01/01/2015 **Ending:** 2/31/2015

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 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 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1	CAMBRIDGE		X	MORTGAGE	7/1/14	$ 6,560,000	$ 6,431,766	5/27/16	3.8900	$ 251,834	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	FIRST BANK		X	LINE OF CREDIT	/ /		40,000	/ /		88	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 6,560,000	$ 6,471,766			$ 251,922	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 6,560,000	$ 6,471,766			$ 251,922	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:** 01/01/2015 **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*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 64,997	$ 69,847	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	204,607	204,607	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,403	53,852	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	300,000	300,000	8
9	Other(specify): ESCROWS		125,511	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 589,007	$ 753,817	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		2,736,049	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		398,472	16
17	Accumulated Depreciation (book methods)		(383,127)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		4,322,882	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(750,450)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 6,423,826	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 589,007	$ 7,177,643	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,156	$ 3,156	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,574	22,574	28
29	Short-Term Notes Payable	40,000	40,000	29
30	Accrued Salaries Payable	23,085	23,085	30
31	Accrued Taxes Payable	2,608	73,807	31
32	Accrued Interest Payable		20,850	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)**	$ 91,423	$ 183,472	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		6,431,766	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)**	$	$ 6,431,766	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 91,423	$ 6,615,238	45
46	**TOTAL EQUITY**	$ 497,584	$ 562,405	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 589,007	$ 7,177,643	47

***(See instructions.)**

Facility Name: PARK POINT SUPPORTIVE LIVING **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	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 2,458,557	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,458,557	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		8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	2,135	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 2,135	14
	D. Other Revenue (specify):		
15	**CABLE TV, PHONE, PENDANT**	27,372	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 27,372	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 2,488,064	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	594,485	19
20	Health Care/ Personal Care	358,035	20
21	General Administration	352,196	21
	B. Capital Expense		
22	Ownership	611,325	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify): PRIOR PERIOD ADJ	5,831	25
26			26
27			27
28	**TOTAL EXPENSES (sum of lines 19 thru 27)**	$ 1,921,872	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 566,192	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 566,192	31