

		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: 1000066

Facility Name: Brookstone of Aledo

Address: 405 S.E. 13th Ave Aledo 61231

Number City Zip Code

County: Mercer

Telephone Number: (309) 582-1132 Fax # 309 582-1134

Federal Employer ID Number:

Date Current Owners were Certified: 09/01/2009

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input 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 checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	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 01/01/2015 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)	Iona Doerfler	
	(Title)	Controller	
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)		
	(Firm Name & Address)		
	(Telephone)	()	Fax # ()

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

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	66	Single Unit Apartment	66	24,090
2		Double Unit Apartment		
3		Other		
4	66	TOTALS	66	24,090

B. Census-For the entire report period.

1	2	3	4	5	
Type of Unit	Resident Days by Unit and Primary Source of Payment				
	Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	4,130	19,695		23,825
6	Double Unit				
7	Other				
8	TOTALS	4,130	19,695	0	23,825

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

98.90%

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?

YESNO

X

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

YESNO

X

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

H. ACCOUNTING BASIS

ACCURAL

X

MODIFIED CASH*CASH*

I. Is your fiscal year identical to your tax year?

X

YESNO

Tax Year: 2015Fiscal Year: 2015

* 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.

STATE OF ILLINOIS

Facility Name: Brookstone of Aledo **Report Period Beginning:** 1/1/2015 **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	164,135	115,764	17,128	297,027		297,027	1
2	Housekeeping, Laundry and Maintenance	56,770	18,657	7,060	82,487		82,487	2
3	Heat and Other Utilities			107,289	107,289		107,289	3
4	Other (specify): Minor Equipment, Building and Ground Maint			34,818	34,818		34,818	4
5	TOTAL General Services	220,905	134,421	166,295	521,621	0	521,621	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	227,539	3,091	31,214	261,844		261,844	6
7	Activities and Social Services	4,225	7,931	759	12,915		12,915	7
8	Other (specify):				0		0	8
9	TOTAL Health Care and Programs	231,764	11,022	31,973	274,759	0	274,759	9
	C. General Administration							
10	Administrative and Clerical	141,848	7,100	61,104	210,052		210,052	10
11	Marketing Materials, Promotions and Advertising			12,272	12,272		12,272	11
12	Employee Benefits and Payroll Taxes			71,132	71,132		71,132	12
13	Insurance-Property, Liability and Malpractice			83,904	83,904		83,904	13
14	Other (specify): Management Fees			146,377	146,377		146,377	14
15	TOTAL General Administration	141,848	7,100	374,789	523,737	0	523,737	15
16	TOTAL Operating Expense	594,517	152,543	573,057	1,320,117	0	1,320,117	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			9,687	9,687		9,687	17
18	Interest				0		0	18
19	Real Estate Taxes			123,032	123,032		123,032	19
20	Rent -- Facility and Grounds			671,654	671,654		671,654	20
21	Rent -- Equipment			38,272	38,272		38,272	21
22	Other (specify):				0		0	22
23	TOTAL Ownership	0	0	842,645	842,645	0	842,645	23
24	GRAND TOTAL (Sum of lines 16 and 23)	594,517	152,543	1,415,702	2,162,762	0	2,162,762	24

Facility Name: Brookstone of Aledo

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants	1	21.65	4
5	Social Service Workers	1	10.31	5
6	Head Cook	1	12.00	6
7	Cook Helpers/Assistants	3	9.21	7
8	Dishwashers			8
9	Maintenance Workers	8	9.48	9
10	Housekeepers			10
11	Laundry			11
12	Managers	1	35.92	12
13	Other Administrative			13
14	Clerical	1	15.98	14
15	Marketing	1	17.92	15
16	Other Resident Assistants	11	8.96	16
17	Total (lines 1 thru 16)	28	\$	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

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				\$ 0	6

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1	Meridian Senior Living LLC	\$ 122,053	1
2			2
Total		\$ 122,053	3

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

Facility Name: Brookstone of Aledo Report Period Beginning: 1/1/2015 Ending: 12/31/2015

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: NRF HEALTHCARE LLC

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		66	04/01/2011	\$ 671,654	10		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		66		\$ 671,654			7

8. Is movable equipment rental included in building rental?
☐ YES ☒ NO

9. Rental amount for movable equipment \$ NA

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					/ /	\$		/ /		\$	1		
2					/ /			/ /			2		
3					/ /			/ /			3		
	Working Capital												
4					/ /			/ /			4		
5					/ /			/ /			5		
6					/ /			/ /			6		
7	TOTAL Facility Related					\$	0	\$	0		\$	0	7
	B. Non-Facility Related												
8					/ /			/ /				8	
9					/ /			/ /				9	
10	TOTALS (lines 7, 8 and 9)					\$	0	\$	0		\$	0	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: Brookstone of Aledo

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 140,175	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	190,864		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,406		6
7	Other Prepaid Expenses	1,779		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Unapplied Cash	58,416		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 442,640	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	23,024		15
16	Equipment, at Historical Cost	30,600		16
17	Accumulated Depreciation (book methods)	(11,520)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	281,577		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 323,681	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 766,321	\$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 28,054	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,767		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(116)		30
31	Accrued Taxes Payable	15,193		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Contract Health Services	1,040		35
36	Prepaid Revenue	14,631		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 61,569	\$ 0	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			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)	\$ 0	\$ 0	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 61,569	\$ 0	45
46	TOTAL EQUITY	\$ 704,752	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 766,321	\$ 0	47

*(See instructions.)

Facility Name: Brookstone of Aledo

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

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

		1	
	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,401,855	1
2	Discounts and Allowances	(3,518)	2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 2,398,337	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	1,300	8
9	Non-Resident Meals	120	9
10	Laundry		10
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$ 1,420	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$ 0	14
	D. Other Revenue (specify):		
15	Cable, Phone, Internet	22,983	15
16	Misc Ancillary Charges and Pendant Fee	365	16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$ 23,348	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 2,423,105	18

		2	
	Expenses	Amount	
	A. Operating Expenses		
19	General Services	521,621	19
20	Health Care/ Personal Care	274,759	20
21	General Administration	523,737	21
	B. Capital Expense		
22	Ownership	842,645	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 2,162,762	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ 260,343	29
	Income Taxes		
30		\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ 260,343	31