

		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: 1000066

Facility Name: Brookstone of Aledo

Address: 405 SE 13th Avenue 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: 9/1/2009

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: William R. List Telephone Number: (410) 363-3200

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 01/01/2019 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)		
Paid Preparer	(Title)	Executive Director	
	(Signed)		(Date)
	(Print Name and Title)	William R. List - Director	
	(Firm Name & Address)	Hertzbach & Company, P.A. 800 Red Brook Blvd., Ste 300 Owings Mills, MD 21117	
	(Telephone)	(410) 363-3200 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

Facility Name Brookstone of AledoReport Period Beginning: 01/01/2019 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	66	Single Unit Apartment	66	32,850	1
2		Double Unit Apartment			2
3		Other			3
4	66	TOTALS	66	32,850	4

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	5,518	20,270		25,788	5
6	Double Unit					6
7	Other					7
8	TOTALS	5,518	20,270		25,788	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 78.50%

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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐I. Is your fiscal year identical to your tax year? ☒ YES ☐ NOTax Year: 12/31/19 Fiscal Year: 12/31/19

* 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

Page 3

Facility Name: Brookstone of Aledo

Report Period Beginning:

01/01/2019

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	171,423	110,725	3,261	285,409		285,409	1
2	Housekeeping, Laundry and Maintenance	69,880	20,240	30,761	120,881	(575)	120,306	2
3	Heat and Other Utilities			112,027	112,027	(20,264)	91,763	3
4	Other (specify):							4
5	TOTAL General Services	241,303	130,965	146,049	518,317	(20,839)	497,478	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	188,635	2,738	6,556	197,929		197,929	6
7	Activities and Social Services	28,588	4,598	99	33,285		33,285	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	217,223	7,336	6,655	231,214		231,214	9
	C. General Administration							
10	Administrative and Clerical	250,503	4,350	228,979	483,832	(500)	483,332	10
11	Marketing Materials, Promotions and Advertising			27,290	27,290	(27,290)		11
12	Employee Benefits and Payroll Taxes			89,315	89,315		89,315	12
13	Insurance-Property, Liability and Malpractice			52,703	52,703		52,703	13
14	Other (specify):		654	42,310	42,964	(42,310)	654	14
15	TOTAL General Administration	250,503	5,004	440,597	696,104	(70,100)	626,004	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	709,029	143,305	593,301	1,445,635	(90,939)	1,354,696	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			28,101	28,101		28,101	17
18	Interest							18
19	Real Estate Taxes			130,800	130,800		130,800	19
20	Rent -- Facility and Grounds			727,020	727,020	(3,000)	724,020	20
21	Rent -- Equipment			9,081	9,081		9,081	21
22	Other (specify):							22
23	TOTAL Ownership			895,002	895,002	(3,000)	892,002	23
24	GRAND TOTAL (Sum of lines 16 and 23)	709,029	143,305	1,488,303	2,340,637	(93,939)	2,246,698	24

Facility Name: Brookstone of Aledo

Report Period Beginning: 01/01/2019 Ending: 12/31/2019

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants	1	13.70	4
5	Social Service Workers	1	40.19	5
6	Head Cook	1	15.83	6
7	Cook Helpers/Assistants	6	9.48	7
8	Dishwashers			8
9	Maintenance Workers	1	16.49	9
10	Housekeepers	2	9.63	10
11	Laundry			11
12	Managers	1	47.73	12
13	Other Administrative	1	16.83	13
14	Clerical			14
15	Marketing	1	34.59	15
16	Other	8	11.36	16
17	Total (lines 1 thru 16)	23	\$ 14.65	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

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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	Meridian Senior Living, LLC	\$ 140,519	1
2			2
Total		\$ 140,519	3

Facility Name: Brookstone of Aledo

Report Period Beginning:

01/01/2019

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					\$	\$		\$	\$	\$	1
2											2
3											3
4											4
5											5
	Improvement Type										
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$	\$		\$	\$	\$	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	\$ 132,225	\$ 23,531	\$ 23,531	\$	var	\$ 58,476	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 132,225	\$ 23,531	\$ 23,531	\$		\$ 58,476	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	Leasehold Improvements	\$ 76,040	\$ \$ 4,570	\$ \$ 28,756	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 76,040	\$ 4,570	\$ 28,756	24

Facility Name: Brookstone of Aledo

Report Period Beginning: 01/01/2019

Ending: 2/31/2019

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease:

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		66	01/01/11	\$ 727,020	10		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		66		\$ 727,020			7

8. Is movable equipment rental included in building rental?

☐ YES ☒ NO

9. Rental amount for movable equipment \$ 9,081

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**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 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					\$	\$			\$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	\$			\$	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

Page 7

Facility Name: Brookstone of Aledo

Report Period Beginning: 01/01/2019

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	\$ 257,351	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	185,989		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,681		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	361,003		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 806,023	\$	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	76,040		15
16	Equipment, at Historical Cost	132,225		16
17	Accumulated Depreciation (book methods)	(87,233)		17
18	Deferred Charges			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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 121,032	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 927,055	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 22,197	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,373		30
31	Accrued Taxes Payable	7,005		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Insurance / RE Taxes	43,878		35
36	Prepaid Revenues	60,342		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 187,795	\$	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)	\$	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 187,795	\$	45
46	TOTAL EQUITY	\$ 739,260	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 927,055	\$	47

*(See instructions.)

Facility Name: Brookstone of Aledo

Report Period Beginning: 01/01/2019

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	\$ 2,796,045	1
2	Discounts and Allowances	(5,368)	2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 2,790,677	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
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$	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)	\$	14
	D. Other Revenue (specify):		
15	Cable TV / Pet Fee	21,694	15
16	Phone / Internet	11,039	16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$ 32,733	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 2,823,410	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	518,317	19
20	Health Care/ Personal Care	231,214	20
21	General Administration	696,104	21
	B. Capital Expense		
22	Ownership	895,002	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)	\$ 2,340,637	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ 482,773	29
	Income Taxes		
30		\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ 482,773	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 707,423	32
33	Private Pay - Net Inpatient Revenue	2,083,254	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,790,677	37