

		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: 1000018

Facility Name: Brookstone Emerld Glen Olney

Address: 1301 North East StOlney62450

County: Richland

Telephone Number: (618) 395-4663Fax # ()

Federal Employer ID Number:

Date Current Owners were Certified: 6/1/2015

Type of Ownership:

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

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Anna KobrzakTelephone Number: (312) 673-4360
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 1/1/19 to 12/31/19 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
Paid Preparer

(Signed)
(Type or Print Name) Steve Hippel
(Title) Chief Financial Officer
(Signed)
(Print Name and Title) Denise GadomskiPartner
(Firm Name & Address) Plante & Moran, PLLC1111 Superior Ave Suite 1250 Cleveland, OH 44114
(Telephone) (216) 274-6514Fax # (248) 233-7349

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 Emerld Glen Olney Report Period Beginning: 1/1/19 Ending: 12/31/19

III. STATISTICAL DATA

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

Date of change in certified units N/A

	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	31	Single Unit Apartment	31	11,315	1
2	4	Double Unit Apartment	4	1,460	2
3		Other		365	3
4	35	TOTALS	35	13,140	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	5,169	4,999		10,168	5
6	Double Unit	449	851		1,300	6
7	Other		365		365	7
8	TOTALS	5,618	6,215		11,833	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 90.05%

D. Indicate the number of paid bed-hold days the SLF had during this year

None Also, indicate the number of unpaid bed-hold days the SLF
had during this year. None (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)

None

H. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☒ YES ☐ NO

Tax Year: 12/31/2019 Fiscal Year: 12/31/2019

* 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? N/A

If no, explain. N/A

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? N/A

If no, explain. N/A

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? N/A

If no, explain. N/A

STATE OF ILLINOIS

Facility Name: Brookstone Emerld Glen Olney

Report Period Beginning:

1/1/19

Ending:

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12/31/19

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	50,070	67,465	752	118,287	(17,008)	101,279	1
2	Housekeeping, Laundry and Maintenance	35,413	37,775	7,477	80,665		80,665	2
3	Heat and Other Utilities			47,178	47,178		47,178	3
4	Other (specify): Trash & Refuse			1,726	1,726		1,726	4
5	TOTAL General Services	85,483	105,240	57,133	247,856	(17,008)	230,848	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	202,323	3,691	5,700	211,714		211,714	6
7	Activities and Social Services	1,804	3,580	151	5,535	(1,417)	4,118	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	204,127	7,271	5,851	217,249	(1,417)	215,832	9
	C. General Administration							
10	Administrative and Clerical	67,316	8,633	110,038	185,987	(7,324)	178,663	10
11	Marketing Materials, Promotions and Advertising	329	2,442	18,102	20,873		20,873	11
12	Employee Benefits and Payroll Taxes			40,047	40,047		40,047	12
13	Insurance-Property, Liability and Malpractice			18,103	18,103		18,103	13
14	Other (specify): Bad Debt, Contributions, Misc			8,075	8,075	(8,075)		14
15	TOTAL General Administration	67,645	11,075	194,365	273,085	(15,399)	257,686	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	357,255	123,586	257,349	738,190	(33,824)	704,366	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			1,330	1,330	9,460	10,790	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			397,129	397,129		397,129	20
21	Rent -- Equipment			8,654	8,654		8,654	21
22	Other (specify):							22
23	TOTAL Ownership			407,113	407,113	9,460	416,573	23
24	GRAND TOTAL (Sum of lines 16 and 23)	357,255	123,586	664,462	1,145,303	(24,364)	1,120,939	24

Facility Name: Brookstone Emerld Glen Olney

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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	6.40	11.76	3
4	Activity Director & Assistants	0.06	14.45	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	0.93	12.94	7
8	Dishwashers			8
9	Maintenance Workers	0.36	18.25	9
10	Housekeepers	0.80	13.07	10
11	Laundry			11
12	Managers Dining Director	0.95	12.67	12
13	Other Administrative ED	0.35	50.72	13
14	Clerical Includes BOM	0.32	47.76	14
15	Marketing	0.01	53.92	15
16	Other AL Director	0.96	22.92	16
17	Total (lines 1 thru 16)	11.14	\$ 15.48	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

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	N/A			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	Senior Lifestyle Corporation	\$ 69,608	1
2			2
Total		\$ 69,608	3

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).

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VIII. OWNERSHIP COSTS**A. Purchase price of land** N/AYear land was acquired N/A**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	Phone/Telecommunications System			2019	12,586		20	629	629	629	6
7	Improvements Within Residents Units			2019	4,183		20	209	209	209	7
8	Corridor Carpet Replacement			2019	34,208		20	1,710	1,710	1,710	8
9											9
10											10
11											11
12											12
13											13
14											14
15	Financial Statement Depreciation					1,330			(1,330)		15
16											16
17	TOTAL (lines 1 thru 16)				\$ 50,977	\$ 1,330		\$ 2,549	\$ 1,219	\$ 2,549	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	\$ 82,406	\$	\$ 8,241	8,241	10	\$ 43,542	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 82,406	\$	\$ 8,241	8,241		\$ 43,542	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

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IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: WC-Olney EG 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 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*		8. Is movable equipment rental included in building rental? ☒ YES ☐ NO
3	Original Building	1998	35	6/1/2015	\$ 397,129	5		3	9. Rental amount for movable equipment \$ 8,654
4	Additions			/ /				4	
5				/ /				5	
6				/ /				6	
7	TOTAL		35		\$ 397,129			7	

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					\$	\$			\$	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.

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/19

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	191,845 (104,454)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,794		6
7	Other Prepaid Expenses	5,470		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 106,655	\$	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	4,183		15
16	Equipment, at Historical Cost	129,200		16
17	Accumulated Depreciation (book methods)	(36,630)		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)	\$ 96,753	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 203,408	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 66,691	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,409		30
31	Accrued Taxes Payable	173		31
32	Accrued Interest Payable	10,823		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Other Accruals: Rent, Legal	340,073		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 440,169	\$	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	Intercompany	894,477		42
43	Deferred Revenue	10,722		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 905,199	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,345,368	\$	45
46	TOTAL EQUITY	\$ (1,141,960)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 203,408	\$	47

*(See instructions.)

Facility Name: Brookstone Emerld Glen Olney

Report Period Beginning: 1/1/19

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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	\$ 1,112,306	1
2	Discounts and Allowances	(89)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,112,217	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	17,008	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 17,008	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	3,108	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 3,108	14
	D. Other Revenue (specify):		
15	Move in Fees, Pet Fees, Late Fees, Misc Inc	108,907	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 108,907	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,241,240	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	247,856	19
20	Health Care/ Personal Care	217,246	20
21	General Administration	273,085	21
	B. Capital Expense		
22	Ownership	407,113	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 1,145,300	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 95,940	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 95,940	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 532,371	32
33	Private Pay - Net Inpatient Revenue	579,846	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,112,217	37

Emerald Glen Olney
Adjustments
12/31/2019

CLIENT_ACT	DESC	DEBIT	TB Acct	IL Acct
4410332000	Meal Revenues	17,008.10	5330.00	IS 1.2
4825402000	Community/Move In Fee - AL	4,000.00	5400.00	IS 10.2
4850350000	Pet Fee Revenue	352.26	5400.00	IS 7.2
4875350000	Miscellaneous Revenue	1,573.94	5400.00	IS 10.2
4885350000	Late Fee Revenue	1,750.00	5400.00	IS 10.2
5565350000	Charitable Contributions	400.00	9760.00	IS 14.3
5790350000	Bad Debt Expense	7,675.00	9765.00	IS 14.3
5551330000	Entertainment Expense	1,065.00	7125.00	IS 7.2
6605350000	Adjustment to SL Depreciation	(9,460.00)	8040.00	IS 17.3
	Total	24,364.30		