

		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: 1000156

Facility Name: Stonebridge of Gurnee

Address: 5980 Washington St Gurnee 61604
 Number City Zip Code

County: Lake

Telephone Number: (847) 596-3211 **Fax #** 224 637-1801

Federal Employer ID Number: _____

Date Current Owners were Certified: 3/28/2018

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL
☐ Charitable Corp.	☐ Individual	☐ State
☐ Trust	☐ Partnership	☐ County
IRS Exemption Code _____	☐ Corporation	☐ Other _____
	☐ "Sub-S" Corp.	
	☒ Limited Liability Co.	
	☐ Trust	
	☐ Other _____	

In the event there are further questions about this report, please contact:

Name: Christonher Dale **Telephone Number:** 847-596-3211
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 1/1/2019 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) <u>Christopher Dale</u> <u>4/22/2019</u> (Date)
	(Type or Print Name) <u>Christopher Dale</u>
Paid Preparer	(Title) <u>Executive Director</u>
	(Signed) _____ (Date)
	(Print Name and Title) _____
	(Firm Name & Address) _____
	(Telephone) (<u> </u>) <u> </u> <u> </u> Fax # (<u> </u>) <u> </u> <u> </u>

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 Stonebridge of GurneeReport Period Beginning: 1/1/2019 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	<u>119</u>	Single Unit Apartment	<u>119</u>	<u>43,435</u>	1
2	<u>1</u>	Double Unit Apartment	<u>1</u>	<u>365</u>	2
3		Other			3
4	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	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	<u>28,490</u>	<u>1,767</u>		<u>30,257</u>	5
6	Double Unit	<u>320</u>			<u>320</u>	6
7	Other					7
8	TOTALS	<u>28,810</u>	<u>1,767</u>		<u>30,577</u>	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 69.81%D. Indicate the number of paid bed-hold days the SLF had during this year 3,776 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 2832 (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

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐I. Is your fiscal year identical to your tax year? ☒ YES ☐ NOTax Year: 2018 Fiscal Year: 1/1/19 - 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? yes If yes, did the facility make all of the required payments of interest and principal? yes
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. _____

Facility Name: Stonebridge of Gurnee

Report Period Beginning:

1/1/2019

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	303,083	225,089		528,172		528,172	1
2	Housekeeping, Laundry and Maintenance	100,578			100,578		100,578	2
3	Heat and Other Utilities			110,943	110,943		110,943	3
4	Other (specify):	82,645			82,645		82,645	4
5	TOTAL General Services	486,306	225,089	110,943	822,338		822,338	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	732,781	34,620		767,401		767,401	6
7	Activities and Social Services	52,126			52,126		52,126	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	784,907	34,620		819,527		819,527	9
	C. General Administration							
10	Administrative and Clerical	418,498	92,128		510,626		510,626	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify):		1,478,134		1,478,134		1,478,134	14
15	TOTAL General Administration	418,498	1,570,262		1,988,760		1,988,760	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,689,711	1,829,971	110,943	3,630,625		3,630,625	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			690,630	690,630		690,630	17
18	Interest			1,380,618	1,380,618		1,380,618	18
19	Real Estate Taxes			227,786	227,786		227,786	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			6,260	6,260		6,260	22
23	TOTAL Ownership			2,305,294	2,305,294		2,305,294	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,689,711	1,829,971	2,416,237	5,935,919		5,935,919	24

Facility Name: Stonebridge of Gurnee

Report Period Beginning 1/1/2019

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	\$ 41.00	1
2	Licensed Practical Nurses	3	27.00	2
3	Certified Nurse Assistants	22	14.50	3
4	Activity Director & Assistants	1	29.00	4
5	Social Service Workers			5
6	Head Cook	2	17.00	6
7	Cook Helpers/Assistants	4	15.00	7
8	Dishwashers	5	11.00	8
9	Maintenance Workers	1	22.00	9
10	Housekeepers	2	13.00	10
11	Laundry			11
12	Managers	2	38.00	12
13	Other Administrative			13
14	Clerical	3	15.00	14
15	Marketing	1	33.60	15
16	Other			16
17	Total (lines 1 thru 16)	46	\$	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		\$	1
2			2
Total		\$	3

Facility Name: Stonebridge of Gurnee

Report Period Beginning:

1/1/2019

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
6	Improvement Type										
7											6
8											7
9											8
10											9
11											10
12											11
13											12
14											13
15											14
16											15
17	TOTAL (lines 1 thru 16)				\$	\$		\$	\$	\$	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	\$	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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: Stonebridge of Gurnee

Report Period Beginning: 1/1/2019

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			/ /	\$			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**		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.

Facility Name: Stonebridge of Gurnee

Report Period Beginning: 1/1/2019

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	\$ 43,401	\$	1
2	Cash-Patient Deposits	10,583		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,217,891		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,094		6
7	Other Prepaid Expenses	273		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,274,242	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,383,052		13
14	Buildings, at Historical Cost	18,027,236		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	669,096		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	3,784,469		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	77,845		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 24,941,698	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 26,215,940	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 119,075	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	195,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	#		31
32	Accrued Interest Payable	# 224,615		32
33	Deferred Compensation	1,027,279		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)	\$ 1,565,969	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	23,490,000		39
40	Bonds Payable			40
41	Deferred Compensation	1,284,152		41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 24,774,152	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 26,340,121	\$	45
46	TOTAL EQUITY	\$ (124,181)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 26,215,940	\$	47

*(See instructions.)

Facility Name: Stonebridge of Gurnee

Report Period Beginning: 1/1/2019

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	\$ 4,191,605	1
2	Discounts and Allowances	(141,254)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,050,351	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	1,050	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,050	14
	D. Other Revenue (specify):		
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,051,401	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	822,338	19
20	Health Care/ Personal Care	819,527	20
21	General Administration	1,988,760	21
	B. Capital Expense		
22	Ownership		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)	\$ 3,630,625	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 420,776	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 420,776	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 2,887,986	32
33	Private Pay - Net Inpatient Revenue	1,162,365	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 4,050,351	37