

		FOR BHF USE			

LL2

Supportive Living Facility

2020

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2020)

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: 1000070

Facility Name: Brookstone Estates Harrisbrg

Address: 165 Ron Morse Drive Harrisburg 62946

Number City Zip Code

County: Saline

Telephone Number: (618) 253-5870 Fax #

Federal Employer ID Number:

Date Current Owners were Certified: 6/1/2015

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: Anna Kobrzak Telephone 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 1/1/20 to 12/31/20 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)	Steve Hippel	
Paid Preparer	(Title)	Chief Financial Officer	
	(Signed)		(Date)
	(Print Name and Title)	Denise A. Leonard, CPA Partner	
	(Firm Name & Address)	Plante & Moran, PLLC 1111 Superior Ave Suite 1250 Cleveland, OH 44114	
	(Telephone)	(216) 274-6514 Fax # (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 Estates Harrisbrg Report Period Beginning: 1/1/20 Ending: 12/31/20

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	39	Single Unit Apartment	39	14,274	1
2	7	Double Unit Apartment	7	2,562	2
3		Other		30	3
4	46	TOTALS	46	16,866	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	8,271	5,144		13,415	5
6	Double Unit		2,049		2,049	6
7	Other	30			30	7
8	TOTALS	8,301	7,193		15,494	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 91.87%

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: 12/31/20 Fiscal Year: 12/31/20

* 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

Page 3

Facility Name: Brookstone Estates Harrisbrg

Report Period Beginning:

1/1/20

Ending:

12/31/20

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	55,735	105,976		161,711	(31,823)	129,888	1
2	Housekeeping, Laundry and Maintenance	32,268	31,510	356	64,134		64,134	2
3	Heat and Other Utilities			50,115	50,115		50,115	3
4	Other (specify):			2,538	2,538		2,538	4
5	TOTAL General Services	88,003	137,486	53,009	278,498	(31,823)	246,675	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	333,848	32,794	4,416	371,058		371,058	6
7	Activities and Social Services	23,003	637	218	23,858	(271)	23,587	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	356,851	33,431	4,634	394,916	(271)	394,645	9
	C. General Administration							
10	Administrative and Clerical	132,533	6,339	161,330	300,202	(10,656)	289,546	10
11	Marketing Materials, Promotions and Advertising	331	2,020	28,765	31,116		31,116	11
12	Employee Benefits and Payroll Taxes			79,010	79,010		79,010	12
13	Insurance-Property, Liability and Malpractice			38,512	38,512		38,512	13
14	Other (specify):			23,614	23,614	(23,614)		14
15	TOTAL General Administration	132,864	8,359	331,231	472,454	(34,270)	438,184	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	577,718	179,276	388,874	1,145,868	(66,364)	1,079,504	16
	Capital Expenses							
	D. Ownership							
17	Depreciation							17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			756,432	756,432		756,432	20
21	Rent -- Equipment			10,840	10,840		10,840	21
22	Other (specify):							22
23	TOTAL Ownership			767,272	767,272		767,272	23
24	GRAND TOTAL (Sum of lines 16 and 23)	577,718	179,276	1,156,146	1,913,140	(66,364)	1,846,776	24

Facility Name: Brookstone Estates Harrisbrg

Report Period Beginning 1/1/20 Ending: 12/31/20

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.32	\$ 20.20	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	9.41	13.27	3
4	Activity Director & Assistants	0.89	12.43	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	1.97	13.60	7
8	Dishwashers			8
9	Maintenance Workers	0.47	15.09	9
10	Housekeepers	0.78	10.80	10
11	Laundry			11
12	Managers (AL Director)	0.61	26.68	12
13	Other Administrative (ED)	0.99	33.45	13
14	Clerical	0.96	32.04	14
15	Marketing	0.01	53.92	15
16	Other: COVID ADJ	0.80	16.15	16
17	Total (lines 1 thru 16)	17.21	\$ 16.15	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	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	SLN Manager SNF, LLC	\$ 107,604	1
2			2
Total		\$ 107,604	3

Facility Name: Brookstone Estates Harrisbrg

Report Period Beginning:

1/1/20

Ending:

12/31/20

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						\$	27	\$	\$	\$	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	*Fixed asset balances were transferred to property company, which is an unrelated entity. Historial fixed assets have been kept on this schedule.										13
14	Detail available upon request										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	\$ 192,614	\$	\$			\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 192,614	\$	\$			\$	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: Brookstone Estates Harrisbrg Report Period Beginning: 1/1/20 Ending: 12/31/20

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: WC-Harrisburg 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	2005	46	6/1/2015	\$ 756,432		3
4	Additions		/ /				4
5			/ /				5
6			/ /				6
7	TOTAL		46	\$ 756,432			7

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

9. Rental amount for movable equipment \$ 10,840

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	IHDA					\$	\$			\$	1
2	IHDA										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 Estates Harrisbrg

Report Period Beginning: 1/1/20

Ending:

12/31/20

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 180	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	147,696 (21,358)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,479		6
7	Other Prepaid Expenses	2,882		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 159,879	\$	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			15
16	Equipment, at Historical Cost			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			21
22	Other Long-Term Assets (specify):	6,423		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,423	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 166,302	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 29,398	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,328		30
31	Accrued Taxes Payable	1,130		31
32	Accrued Interest Payable	25,980		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Other	1,220,788		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,300,624	\$	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	1,686,048		42
43	Deferred Revenues	30,731		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 1,716,779	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,017,403	\$	45
46	TOTAL EQUITY	\$ (2,851,101)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 166,302	\$	47

*(See instructions.)

Facility Name: Brookstone Estates Harrisbrg

Report Period Beginning: 1/1/20

Ending:

12/31/20

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	\$ 1,751,281	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,751,281	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	87,231	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	31,823	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 119,054	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	81	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 81	14
	D. Other Revenue (specify):		
15	Other Misc. Revenues	8,675	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 8,675	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,879,091	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	278,498	19
20	Health Care/ Personal Care	394,916	20
21	General Administration	472,454	21
	B. Capital Expense		
22	Ownership	767,272	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)	\$ 1,913,140	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (34,049)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (34,049)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 895,183	32
33	Private Pay - Net Inpatient Revenue	856,098	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,751,281	37