

		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: 1000010

Facility Name: Brookstone Estates Paris

Address: 146 Brookstone LaneParis61944

County: Edgar

Telephone Number: (217) 463-5871Fax # ()

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 1/1/20 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
(Title) Chief Financial Officer

Paid Preparer

(Signed)
(Date)
(Print Name and Title) Denise A. Leonard, CPAPartner
(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

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			3
4	46	TOTALS	46	16,836	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	6,281	7,420		13,701	5
6	Double Unit		2,562		2,562	6
7	Other					7
8	TOTALS	6,281	9,982		16,263	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.60%

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

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Facility Name: Brookstone Estates Paris

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 1	Supplies 2	Other 3	Total 4			
	A. General Services							
1	Dietary and Food Purchase	55,284	111,289	2,980	169,553	(31,620)	137,933	1
2	Housekeeping, Laundry and Maintenance	32,538	25,741		58,279		58,279	2
3	Heat and Other Utilities			52,248	52,248		52,248	3
4	Other (specify):			1,260	1,260		1,260	4
5	TOTAL General Services	87,822	137,030	56,488	281,340	(31,620)	249,720	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	334,749	44,477	4,144	383,370		383,370	6
7	Activities and Social Services		341	160	501	(240)	261	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	334,749	44,818	4,304	383,871	(240)	383,631	9
	C. General Administration							
10	Administrative and Clerical	90,267	6,034	161,784	258,085	(4,282)	253,803	10
11	Marketing Materials, Promotions and Advertising	331	914	35,334	36,579		36,579	11
12	Employee Benefits and Payroll Taxes			72,061	72,061		72,061	12
13	Insurance-Property, Liability and Malpractice			27,174	27,174		27,174	13
14	Other (specify):			6,938	6,938	(6,938)		14
15	TOTAL General Administration	90,598	6,948	303,291	400,837	(11,220)	389,617	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	513,169	188,796	364,083	1,066,048	(43,080)	1,022,968	16
	Capital Expenses							
	D. Ownership							
17	Depreciation							17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			724,547	724,547		724,547	20
21	Rent -- Equipment			12,945	12,945		12,945	21
22	Other (specify):							22
23	TOTAL Ownership			737,492	737,492		737,492	23
24	GRAND TOTAL (Sum of lines 16 and 23)	513,169	188,796	1,101,575	1,803,540	(43,080)	1,760,460	24

Facility Name: Brookstone Estates Paris

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		\$	1
2	Licensed Practical Nurses	0.64	22.25	2
3	Certified Nurse Assistants	10.18	12.13	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	2.10	12.65	7
8	Dishwashers			8
9	Maintenance Workers	0.49	15.31	9
10	Housekeepers	0.64	12.72	10
11	Laundry			11
12	Managers (AL Director)	0.35	38.00	12
13	Other Administrative (ED)	1.00	32.07	13
14	Clerical	0.30	38.30	14
15	Marketing	0.01	53.92	15
16	Other	0.66	15.09	16
17	Total (lines 1 thru 16)	16.37	\$ 15.09	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	SLN Manager SNF, LLC.	\$ 116,120	1
2			2
Total		\$ 116,120	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? \$ _____
(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).

Facility Name: Brookstone Estates Paris

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						\$		\$	\$		1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Phone System Upgrades			2019	29,652						6
7	Improvements Within Resident Units			2019	6,474						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.										
14	Detail available upon request										14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 36,126	\$		\$	\$	\$	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		\$ 191,100	\$	\$			\$	18
19								19
20	TOTAL (lines 18 and 19)	\$ 191,100	\$	\$	\$		\$	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 Paris

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IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: WC-Paris 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*	
3	Original Building	2001	46	6/1/2015	\$ 724,547	5		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		46		\$ 724,547			7

8. Is movable equipment rental included in building rental?

☒ YES

☐ NO

9. Rental amount for movable equipment \$ 12,945

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.

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Facility Name: Brookstone Estates Paris

Report Period Beginning: 1/1/20

Ending:

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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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	45,293 (19,137)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,693		6
7	Other Prepaid Expenses	2,923		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 49,772	\$	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):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 49,772	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 60,182	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,407		30
31	Accrued Taxes Payable	1,267		31
32	Accrued Interest Payable	26,889		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Other	1,147,802		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,254,547	\$	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	1,500,912		42
43	Deferred Revenues	52,630		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 1,553,542	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,808,089	\$	45
46	TOTAL EQUITY	\$ (2,758,317)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 49,772	\$	47

*(See instructions.)

Facility Name: Brookstone Estates Paris

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	\$ 1,779,985	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,779,985	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	82,226	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	31,620	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 113,846	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
	D. Other Revenue (specify):		
15	Other Misc. Revenues	2,350	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 2,350	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,896,181	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	281,340	19
20	Health Care/ Personal Care	348,022	20
21	General Administration	436,686	21
	B. Capital Expense		
22	Ownership	737,492	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)	\$ 1,803,540	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 92,641	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 92,641	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 682,580	32
33	Private Pay - Net Inpatient Revenue	1,097,405	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,779,985	37