

		FOR BHF USE			

LL2

Supportive Living Facility

2021

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2021)

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 Ests Emerald Glen

Address: 1301 North East StOlney62450

County: Richland

Telephone Number: (618) 395-4663 Fax #

Federal Employer ID Number:

Date Current Owners were Certified: 6/1/2021

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: Steven N. Lavenda
Telephone Number: (847) - 282- 6300
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 6/1/2021 to 12/31/2021 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)
(Title)

Paid Preparer

(Signed)
(Print Name and Title) Steven N. Lavenda, CPA Partner
(Firm Name & Address) Marcum LLP Nine Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax (847) 282-6301

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	31	Single Unit Apartment	31	6,634	1
2	4	Double Unit Apartment	4	856	2
3		Other		179	3
4	35	TOTALS	35	7,669	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	2,080	1,890		3,970	5
6	Double Unit	410	277		687	6
7	Other		179		179	7
8	TOTALS	2,490	2,346		4,836	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 63.06%

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

N/A Also, indicate the number of unpaid bed-hold days the SLF had during this year. N/A (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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2021 Fiscal Year: 12/31/2021

* 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 Ests Emerald Glen

Report Period Beginning:

6/1/2021

Ending:

12/31/2021

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	29,957	38,775	1,104	69,836		69,836	1
2	Housekeeping, Laundry and Maintenance	23,255	8,482	11,523	43,260	921	44,181	2
3	Heat and Other Utilities			35,524	35,524	(7,070)	28,454	3
4	Other (specify):							4
5	TOTAL General Services	53,212	47,257	48,151	148,620	(6,149)	142,471	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	107,690		13,301	120,991	1,333	122,324	6
7	Activities and Social Services	4,001	1,295	400	5,696	354	6,050	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	111,691	1,295	13,701	126,687	1,687	128,374	9
	C. General Administration							
10	Administrative and Clerical	50,915	3,558	117,551	172,024	(31,990)	140,034	10
11	Marketing Materials, Promotions and Advertising		1,078	17,619	18,697	3,104	21,801	11
12	Employee Benefits and Payroll Taxes			44,991	44,991		44,991	12
13	Insurance-Property, Liability and Malpractice			14,275	14,275	601	14,876	13
14	Other (specify):					4,334	4,334	14
15	TOTAL General Administration	50,915	4,636	194,436	249,987	(23,951)	226,036	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	215,818	53,188	256,288	525,294	(28,413)	496,881	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			48,417	48,417	9,811	58,228	17
18	Interest							18
19	Real Estate Taxes			44,212	44,212		44,212	19
20	Rent -- Facility and Grounds			15,558	15,558	2,190	17,748	20
21	Rent -- Equipment			1,898	1,898		1,898	21
22	Other (specify):							22
23	TOTAL Ownership			110,085	110,085	12,001	122,086	23
24	GRAND TOTAL (Sum of lines 16 and 23)	215,818	53,188	366,373	635,379	(16,412)	618,967	24

STATE OF ILLINOIS		Page 3A
Brookstone Eats Emerald Glen		
Report Period Beginning:	6/1/2021	
Ending:	12/31/2021	
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1 Non-Straight Line Depreciation	8,564	17 1
2 Resident Gifts	(280)	10 2
3 Meals & Entertainment	(175)	10 3
4 Cable TV	(7,089)	03 4
5 Management Fees	(35,000)	10 5
6 Partnership Management Fees	(21,818)	10 6
7 Bank Service Charges	(70)	10 7
8 Pathway Management Allocation		10 8
9 Maintenance	921	02 9
10 Utilities	19	03 10
11 Health Care / Personal Care	1,333	06 11
12 Community Life	354	07 12
13 Administrative-SLF Only	6,119	10 13
14 Marketing	3,104	11 14
15 Insurance	601	13 15
16 Employee Benefits-SLF Only	462	14 16
17 Depreciation	1,247	17 17
18 Rent - Building	2,190	20 18
19 Administrative	19,234	10 19
20 Employee Benefits	3,872	14 20
21		21
22		22
23		23
24		24
25		25
26		26
27		27
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100		100
101 Total	(16,412)	101

Facility Name: Brookstone Ests Emerald Glen

Report Period Beginning 6/1/2021 Ending: 12/31/2021

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.38	\$ 23.78	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	3.30	12.99	3
4	Activity Director & Assistants	0.14	14.04	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	0.92	15.71	7
8	Dishwashers			8
9	Maintenance Workers	0.20	19.82	9
10	Housekeepers	0.61	11.94	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.22	20.10	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	6.75	\$ 15.37	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
See Attached			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
See Attached					

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	Jerry Finis		0.14	\$ 648	1
2					2
3					3
4					4
5					5
Total				\$ 648	6

VI. (B) Management fees paid to unrelated parties Amount of Fee

1		\$	1
2			2
Total		\$	3

Facility Name: Brookstone Ests Emerald Glen

Report Period Beginning:

6/1/2021

Ending:

12/31/2021

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	Total From Supplemental Page 5's				3,493		20	175	175	175	6
7											7
8	Allocated from Pathway Management					1,247			(1,247)		8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 3,493	\$ 1,247		\$ 175	\$ (1,072)	\$ 175	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	\$ 580,534	\$ 48,417	\$ 58,053	9,636		\$ 58,053	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	\$ 580,534	\$ 48,417	\$ 58,053	9,636		\$ 58,053	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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Leasehold Improvements	2021	\$ 3,493	\$ 1,247	20	\$ 175	\$ (1,072)	\$ 175	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,493	\$ 1,247		\$ 175	\$ (1,072)	\$ 175	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1			\$	\$ 1,247		\$	\$ (1,247)	\$	1
2									2
3									3
4									4
5									5
6									6
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8									8
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$ 1,247		\$	\$ (1,247)	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		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
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name: Brookstone Ests Emerald Glen

Report Period Beginning: 6/1/2021

Ending: 12/31/2021

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: REIT

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		8. Is movable equipment rental included in building rental?
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*		<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Original Building			/ /	\$ 15,000			3	9. Rental amount for movable equipment \$ 1,898
4	Additions			/ /				4	
5	Offsite Storage			/ /	558			5	
6	Allocated from Pathway			/ /	2,190			6	
7	TOTAL				\$ 17,748			7	

8. Is movable equipment rental included in building rental?

☐ YES ☐ NO

9. Rental amount for movable equipment \$ 1,898

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.

STATE OF ILLINOIS

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Facility Name: Brookstone Ests Emerald Glen

Report Period Beginning: 6/1/2021

Ending: 12/31/2021

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2021

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 199,173	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	233,081		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,772		6
7	Other Prepaid Expenses	4,361		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	512		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 447,899	\$	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	3,493		15
16	Equipment, at Historical Cost	580,534		16
17	Accumulated Depreciation (book methods)	(48,417)		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): See Attached			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 535,610	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 983,509	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 224,686	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,226		30
31	Accrued Taxes Payable	72,293		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36	See Attached	757,282		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,072,487	\$	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	See Attached			43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,072,487	\$	45
46	TOTAL EQUITY	\$ (88,978)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 983,509	\$	47

*(See instructions.)

Facility Name: Brookstone Ests Emerald Glen

Report Period Beginning: 6/1/2021

Ending:

12/31/2021

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	\$ 519,356	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 519,356	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		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
	D. Other Revenue (specify):		
15	See Attached	8,515	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 8,515	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 527,871	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	148,620	19
20	Health Care/ Personal Care	126,687	20
21	General Administration	249,987	21
	B. Capital Expense		
22	Ownership	110,085	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)	\$ 635,379	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (107,508)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (107,508)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 348,996	32
33	Private Pay - Net Inpatient Revenue	170,360	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 519,356	37