

		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: 1000008

Facility Name: Brookstone Estates Fairfield

Address: 315 North Market Fairfield 62837

County: Wayne

Telephone Number: (618) 842-5875 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	39	Single Unit Apartment	39	8,346	1
2	7	Double Unit Apartment	7	1,498	2
3		Other		376	3
4	46	TOTALS	46	10,220	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	2,294	2,952		5,246	5
6	Double Unit		802		802	6
7	Other	135	241		376	7
8	TOTALS	2,429	3,995		6,424	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 62.86%

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 Estates Fairfield

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			
	<b>A. General Services</b>							
1	Dietary and Food Purchase	40,786	48,237	295	89,318		89,318	1
2	Housekeeping, Laundry and Maintenance	26,683	4,872	14,887	46,442	1,223	47,665	2
3	Heat and Other Utilities			41,109	41,109	(2,411)	38,698	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	67,469	53,109	56,291	176,869	(1,188)	175,681	5
	<b>B. Health Care and Programs</b>							
6	Health Care/ Personal Care	137,715		825	138,540	1,771	140,311	6
7	Activities and Social Services	8,200	220		8,420	470	8,890	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	145,915	220	825	146,960	2,241	149,201	9
	<b>C. General Administration</b>							
10	Administrative and Clerical	52,378	1,475	139,575	193,428	(34,530)	158,898	10
11	Marketing Materials, Promotions and Advertising		116	20,100	20,216	4,123	24,339	11
12	Employee Benefits and Payroll Taxes			58,389	58,389		58,389	12
13	Insurance-Property, Liability and Malpractice			20,434	20,434	798	21,232	13
14	Other (specify):					5,758	5,758	14
15	<b>TOTAL General Administration</b>	52,378	1,591	238,498	292,467	(23,851)	268,616	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	265,762	54,920	295,614	616,296	(22,798)	593,498	16
	<b>Capital Expenses</b>							
	<b>D. Ownership</b>							
17	Depreciation			32,584	32,584	6,517	39,101	17
18	Interest							18
19	Real Estate Taxes			57,931	57,931		57,931	19
20	Rent -- Facility and Grounds			167,523	167,523	2,909	170,432	20
21	Rent -- Equipment			1,542	1,542		1,542	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			259,580	259,580	9,426	269,006	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	265,762	54,920	555,194	875,876	(13,372)	862,504	24

STATE OF ILLINOIS		Page 3A
Brookstone Estates Fairfield		
Report Period Beginning:	6/1/2021	
Ending:	12/31/2021	
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1 Non-Straight Line Depreciation	4,868	17 1
2 Resident Gifts	(220)	10 2
3 Bank Service Charges	(108)	10 3
4 Meals & Entertainment	(175)	10 4
5 Cable TV	(2,437)	03 5
6 Management Fees	(42,000)	10 6
7 Partnership Management Fee	(21,819)	10 7
8 Bad Debt Expense	(3,886)	10 8
9 Pathway Management Allocation		9 9
10 Maintenance	1,223	02 10
11 Utilities	26	03 11
12 Health Care / Personal Care	1,771	06 12
13 Community Life	470	07 13
14 Administrative-SLF Only	8,128	10 14
15 Marketing	4,123	11 15
16 Insurance	798	13 16
17 Employee Benefits-SLF Only	614	14 17
18 Depreciation	1,657	17 18
19 Rent - Building	2,909	20 19
20 Administrative	25,550	10 20
21 Employee Benefits	5,144	14 21
22		22
23		23
24		24
25		25
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93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101 Total	(13,372)	101

Facility Name: Brookstone Estates Fairfield

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		\$	1
2	Licensed Practical Nurses	0.42	24.22	2
3	Certified Nurse Assistants	4.38	12.79	3
4	Activity Director & Assistants	0.32	12.46	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	1.38	14.26	7
8	Dishwashers			8
9	Maintenance Workers	0.39	15.41	9
10	Housekeepers	0.57	12.01	10
11	Laundry			11
12	Managers			12
13	Other Administrative	0.88	28.54	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	8.33	\$ 15.33	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		0.18	\$ 861	1
2					2
3					3
4					4
5					5
Total				\$ 861	6

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

1		\$	1
2			2
Total		\$	3

Facility Name: Brookstone Estates Fairfield

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
	<b>Improvement Type</b>										
6	Total From Supplemental Page 5's										6
7											7
8	Allocated from Pathway Management					1,657			(1,657)		8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$	\$ 1,657		\$	(1,657)	\$	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	\$ 391,014	\$ 32,584	\$ 39,101	6,517		\$ 39,101	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	\$ 391,014	\$ 32,584	\$ 39,101	6,517		\$ 39,101	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			\$	\$ 1,657		\$	\$ (1,657)	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$ 1,657		\$	\$ (1,657)	\$	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			\$	\$ 1,657		\$	\$ (1,657)	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$ 1,657		\$	\$ (1,657)	\$	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
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
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 Estates Fairfield

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			/ /	\$ 167,342			3	9. Rental amount for movable equipment \$ 1,542
4	Additions			/ /				4	
5	Offsite Storage			/ /	181			5	
6	Allocated from Pathway			/ /	2,909			6	
7	TOTAL				\$ 170,432			7	

8. Is movable equipment rental included in building rental?

☐ YES ☐ NO

9. Rental amount for movable equipment \$ 1,542

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 Estates Fairfield

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 355,703	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	238,734		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,462		6
7	Other Prepaid Expenses	5,089		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <a href="#">See Attached</a>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 613,988	\$	10
	<b>B. Long-Term Assets</b>			
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	391,014		16
17	Accumulated Depreciation (book methods)	(32,584)		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): <a href="#">See Attached</a>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 358,430	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 972,418	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 344,427	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,380		30
31	Accrued Taxes Payable	97,828		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36	<a href="#">See Attached</a>	671,679		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 1,134,314	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43	<a href="#">See Attached</a>			43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 1,134,314	\$	45
46	<b>TOTAL EQUITY</b>	\$ (161,896)	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 972,418	\$	47

\*(See instructions.)

Facility Name: Brookstone Estates Fairfield

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	
	<b>I. Revenue</b>	<b>Amount</b>	
	<b>A. SLF Resident Care</b>		
1	Gross SLF Resident Revenue	\$ 675,629	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	\$ 675,629	3
	<b>B. Other Operating Revenue</b>		
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	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	\$	11
	<b>C. Non-Operating Revenue</b>		
12	Contributions		12
13	Interest and Other Investment Income	5,050	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	\$ 5,050	14
	<b>D. Other Revenue (specify):</b>		
15	See Attached	13,108	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	\$ 13,108	17
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	\$ 693,787	18

		2	
	<b>II. Expenses</b>	<b>Amount</b>	
	<b>A. Operating Expenses</b>		
19	General Services	176,869	19
20	Health Care/ Personal Care	146,960	20
21	General Administration	292,467	21
	<b>B. Capital Expense</b>		
22	Ownership	259,580	22
	<b>C. Other Expenses</b>		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	\$ 875,876	28
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	\$ (182,089)	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	\$ (182,089)	31
	<b>III. Net Resident Care Revenue detailed by Payer Source</b>		
32	Medicaid - Net Inpatient Revenue	\$ 238,653	32
33	Private Pay - Net Inpatient Revenue	436,976	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	\$ 675,629	37