

		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: 1000070

Facility Name: Brookstone Estates Harrisbrg

Address: 165 Ron Morse Drive Harrisburg 62946

County: Saline

Telephone Number: (618) 253-5870 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			3
4	46	TOTALS	46	9,844	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	4,400	2,737		7,137	5
6	Double Unit		1,090		1,090	6
7	Other					7
8	TOTALS	4,400	3,827		8,227	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 83.57%

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: 12/31/21 Fiscal Year: 12/31/21

* 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 Harrisbrg

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	49,875	54,584	817	105,276	(95)	105,181	1
2	Housekeeping, Laundry and Maintenance	18,470	8,194	9,298	35,962	3,495	39,457	2
3	Heat and Other Utilities			34,324	34,324	(5,565)	28,759	3
4	Other (specify):							4
5	TOTAL General Services	68,345	62,778	44,439	175,562	(2,165)	173,397	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	208,760		905	209,665	2,268	211,933	6
7	Activities and Social Services	11,234	608		11,842	602	12,444	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	219,994	608	905	221,507	2,870	224,377	9
	C. General Administration							
10	Administrative and Clerical	66,819	1,823	153,711	222,353	(37,191)	185,162	10
11	Marketing Materials, Promotions and Advertising		1,104	19,712	20,816	5,280	26,096	11
12	Employee Benefits and Payroll Taxes			73,439	73,439		73,439	12
13	Insurance-Property, Liability and Malpractice			22,681	22,681	1,022	23,703	13
14	Other (specify):					7,375	7,375	14
15	TOTAL General Administration	66,819	2,927	269,543	339,289	(23,514)	315,775	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	355,158	66,313	314,887	736,358	(22,809)	713,549	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			61,457	61,457	12,218	73,675	17
18	Interest							18
19	Real Estate Taxes			95,565	95,565		95,565	19
20	Rent -- Facility and Grounds			119,672	119,672	3,725	123,397	20
21	Rent -- Equipment			6,283	6,283		6,283	21
22	Other (specify):							22
23	TOTAL Ownership			282,977	282,977	15,943	298,920	23
24	GRAND TOTAL (Sum of lines 16 and 23)	355,158	66,313	597,864	1,019,335	(6,866)	1,012,469	24

STATE OF ILLINOIS		Page 3A
Brookstone Estates Harrisburg		
Report Period Beginning:	6/1/2021	
Ending:	12/31/2021	
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1 Non-Straight Line Depreciation	10,096	17 1
2 Guest Meals	(95)	01 2
3 Other Income	(31)	10 3
4 Bank Service Charges	(147)	10 4
5 Resident Gifts	(59)	10 5
6 Meals & Entertainment	(193)	10 6
7 Cable TV	(5,598)	03 7
8 Management Fees	(46,278)	10 8
9 Partnership Management Fees	(21,818)	10 9
10 Additional R&M	1,929	02 10
11 Bad Debt Expense	(11,795)	10 11
12 Pathway Management Allocation		
13 Maintenance	1,566	02 12
14 Utilities	33	03 13
15 Health Care / Personal Care	2,268	06 14
16 Community Life	602	07 15
17 Administrative-SLF Only	10,409	10 16
18 Marketing	5,280	11 17
19 Insurance	1,022	13 18
20 Employee Benefits-SLF Only	787	14 19
21 Depreciation	2,122	17 20
22 Rent - Building	3,725	20 21
23 Administrative	32,720	10 22
24 Employee Benefits	6,588	14 23
25		
26		
27		
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100		
101 Total	(6,866)	

Facility Name: Brookstone Estates Harrisbrg

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	0.48	\$ 32.09	1
2	Licensed Practical Nurses	0.06	22.41	2
3	Certified Nurse Assistants	5.74	14.53	3
4	Activity Director & Assistants	0.36	14.80	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	1.69	14.19	7
8	Dishwashers			8
9	Maintenance Workers	0.27	14.58	9
10	Housekeepers	0.38	12.72	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.12	28.58	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	10.13	\$ 16.86	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		0.23	\$ 1,102	1
2					2
3					3
4					4
5					5
Total				\$ 1102	6

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

1		\$	1
2			2
Total		\$	3

Facility Name: Brookstone Estates Harrisbrg

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				3,485		20	174	174	174	6
7											7
8	Allocated from Pathway Management					2,122			(2,122)		8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 3,485	\$ 2,122		\$ 174	\$ (1,948)	\$ 174	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	\$ 735,012	\$ 61,457	\$ 73,501	12,044		\$ 73,501	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	\$ 735,012	\$ 61,457	\$ 73,501	12,044		\$ 73,501	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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 <u>Carpeting</u>	2021	\$ 3,485	\$ 2,122	20	\$ 174	\$ (1,948)	\$ 174	1
2								2
3								3
4								4
5								5
6								6
7								7
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30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,485	\$ 2,122		\$ 174	\$ (1,948)	\$ 174	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			\$	\$ 2,122		\$	\$ (2,122)	\$	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)		\$	\$ 2,122		\$	\$ (2,122)	\$	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
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8									8
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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 Estates Harrisbrg 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	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building			/ /	\$ 119,329			3
4	Additions			/ /				4
5	Offsite Storage			/ /	343			5
6	Allocated from Pathway			/ /	3,725			6
7	TOTAL				\$ 123,397			7

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

9. Rental amount for movable equipment \$ 6,283

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 Harrisbrg

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	\$ 374,357	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	352,461		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,027		6
7	Other Prepaid Expenses	2,554		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	5,782		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 751,181	\$	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	5,414		15
16	Equipment, at Historical Cost	735,012		16
17	Accumulated Depreciation (book methods)	(61,457)		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)	\$ 678,969	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,430,150	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 329,066	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,092		30
31	Accrued Taxes Payable	162,905		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	971,395		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,495,458	\$	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)	\$ 1,495,458	\$	45
46	TOTAL EQUITY	\$ (65,308)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,430,150	\$	47

*(See instructions.)

Facility Name: Brookstone Estates Harrisbrg

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	\$ 928,000	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 928,000	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	95	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 95	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	6,172	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 6,172	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 934,267	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	175,562	19
20	Health Care/ Personal Care	221,507	20
21	General Administration	339,289	21
	B. Capital Expense		
22	Ownership	282,977	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)	\$ 1,019,335	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (85,068)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (85,068)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 532,706	32
33	Private Pay - Net Inpatient Revenue	395,294	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 928,000	37