FOR BHF USE

LL2

Supportive Living Facility

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)

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: 1000066

Facility Name: Brookstone of Aledo

Address: 405 SE 13th Avenue (Number) Aledo (City) 61231 (Zip Code)

County: Mercer

Telephone Number: (309) 582-1132 **Fax #** 309 582-1134

Federal Employer ID Number:

Date Current Owners were Certified: 09/01/2009

Type of Ownership:

	VOLUNTARY, NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William R. List **Telephone Number:** (410 363-3200
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 01/01/2017 to 12/31/2017 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) Mr. Dustin McDonald
(Title) Exectutive Director

Paid Preparer

(Signed) (Date)
(Print Name and Title) William R. List - Director
(Firm Name & Address) Hertzbach & Company, P.A.
800 Red Brook Blvd., Suite 300, Owings Mills, MD 2111
(Telephone) 410 363-3200 Fax # ( )

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 of Aledo Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	66	Single Unit Apartment	66	24,090	1
2		Double Unit Apartment			2
3		Other			3
4	66	TOTALS	66	24,090	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	4,650	18,463		23,113	5
6	Double Unit					6
7	Other					7
8	TOTALS	4,650	18,463		23,113	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 95.94%

D. Indicate the number of paid bed-hold days the SLF had during this year _____ **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** _____ **(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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/2017 Fiscal Year: 12/31/2017
* 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 principle?** _____
If no, explain. _____

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 principle?** _____
If no, explain. _____

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 principle?** _____
If no, explain. _____

Facility Name: Brookstone of Aledo **Report Period Beginning: 01/01/2017 Ending: 12/31/2017**

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	172,378	121,840	336	294,554		294,554	1
2	Housekeeping, Laundry and Maintenance	51,307	18,969	29,842	100,118		100,118	2
3	Heat and Other Utilities			115,313	115,313	(19,221)	96,092	3
4	Other (specify):							4
5	**TOTAL General Services**	223,685	140,809	145,491	509,985	(19,221)	490,764	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	181,192	3,253	3,943	188,388		188,388	6
7	Activities and Social Services	14,886	5,561	182	20,629		20,629	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	196,078	8,814	4,125	209,017		209,017	9
	C. General Administration							
10	Administrative and Clerical	191,694	4,621	200,260	396,575	(538)	396,037	10
11	Marketing Materials, Promotions and Advertising			30,035	30,035	(30,035)		11
12	Employee Benefits and Payroll Taxes			111,995	111,995		111,995	12
13	Insurance-Property, Liability and Malpractice			41,790	41,790		41,790	13
14	Other (specify): Uniforms(2) and Bad Debts(3)		1,941	33,105	35,046	(33,105)	1,941	14
15	**TOTAL General Administration**	191,694	6,562	417,185	615,441	(63,678)	551,763	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	611,457	156,185	566,801	1,334,443	(82,899)	1,251,544	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			17,521	17,521		17,521	17
18	Interest							18
19	Real Estate Taxes			123,032	123,032		123,032	19
20	Rent -- Facility and Grounds			698,789	698,789		698,789	20
21	Rent -- Equipment			6,931	6,931		6,931	21
22	Other (specify):							22
23	**TOTAL Ownership**			846,273	846,273		846,273	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	611,457	156,185	1,413,074	2,180,716	(82,899)	2,097,817	24

Facility Name: Brookstone of Aledo **Report Period Beginning: 01/01/2017 Ending: 12/31/2017**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0	$ 20.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants	1	11.34	4
5	Social Service Workers	1	11.44	5
6	Head Cook	1	14.90	6
7	Cook Helpers/Assistants	5	9.33	7
8	Dishwashers			8
9	Maintenance Workers	1	14.87	9
10	Housekeepers	1	8.68	10
11	Laundry			11
12	Managers	1	33.11	12
13	Other Administrative	1	15.97	13
14	Clerical	0	13.77	14
15	Marketing	1	21.16	15
16	Other **Resident Assistants**	9	12.06	16
17	**Total (lines 1 thru 16)**	22	$ 12.93	17

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				$	1
2					2
3					3
4					4
5					5
			Total	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	Meridian Senior Living, LLC	$ 116,614	1
2			2
		Total $ 116,614	3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES				OTHER RELATED BUSINESS ENTITIES				
Name	1	City	2	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** [X]

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** [X]

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 of Aledo Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											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	$ 63,752	$ 9,653	$ 9,653	$	various	$ 23,037	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 63,752	$ 9,653	$ 9,653	$		$ 23,037	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	Leasehold Improvements	$ 35,031	$ $ 7,868	$ $ 19,966	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	$ 35,031	$ 7,868	$ 19,966	24

Facility Name: Brookstone of Aledo **Report Period Beginning:** 01/01/2017 **Ending:** 2/31/2017

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: HP Aledo, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? [X] 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		66	04/01/11	$ 698,789	10		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		66		$ 698,789			7

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

9. Rental amount for movable equipment $

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 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	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.

Facility Name: Brookstone of Aledo **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 192,048	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	662,644		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	925		6
7	Other Prepaid Expenses	5,648		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrows / Security Deposit	324,334		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,185,599	$	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	35,031		15
16	Equipment, at Historical Cost	63,752		16
17	Accumulated Depreciation (book methods)	(43,003)		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)**	$ 55,780	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,241,379	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 179,295	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(1,247)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,131		30
31	Accrued Taxes Payable	1,155		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Insurance / RE Taxes	103,854		35
36	Prepaid Revenues	61,342		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 380,530	$	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				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 380,530	$	45
46	**TOTAL EQUITY**	$ 860,849	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 1,241,379	$	47

***(See instructions.)**

Facility Name: Brookstone of Aledo **Report Period Beginning: 01/01/2017 Ending: 12/31/2017**

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 2,388,249	1
2	Discounts and Allowances	(13,505)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,374,744	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services	534	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	600	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 1,134	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	**Cable TV**	19,221	15
16	**Phone / Internet**	538	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 19,759	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 2,395,637	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	509,985	19
20	Health Care/ Personal Care	209,017	20
21	General Administration	615,441	21
	B. Capital Expense		
22	Ownership	846,273	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)**	$ 2,180,716	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 214,921	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 214,921	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 378,670	32
33	Private Pay - Net Inpatient Revenue	1,996,074	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 2,374,744	37