	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: 1000018

Facility Name: Brookstone Emerald Glen Olny

Address: 1301 North East St (Number) Olney (City) 62450 (Zip Code)

County: Richland

Telephone Number: (618) 395-4663 **Fax #** ( )

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/17 to 12/31/17 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)	Chris Joos Partner
	(Firm Name & Address)	Plante & Moran, PLLC 250 South High Street, Suite 100
	(Telephone)	(614) 222-9040 Fax (614) 221-3535

In the event there are further questions about this report, please contact:
Name: Anna Kobrzak Telephone Number: (312 673-4360
Email Address:

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 Emerald Glen Olny   Report Period Beginning: 1/1/17 Ending: 12/31/17

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	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	11,315	1
2	4	Double Unit Apartment	4	1,460	2
3		Other			3
4	35	TOTALS	35	12,775	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	5,110	5,475		10,585	5
6	Double Unit		730		730	6
7	Other					7
8	TOTALS	5,110	6,205		11,315	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.57%

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

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO

Tax Year: 12/31/17 Fiscal Year: 12/31/17

* 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.

Steve Hippel

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? NO If yes, did t Chief Financial Officer 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 Emerald Glen Olny | Report Period Beginning: 1/1/17 | Ending: 12/31/17

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassifications	Adjusted	
		Salary/Wage	Supplies	Other	Total	and Adjustments	Total	
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	52,003	74,123	396	126,522		126,522	1
2	Housekeeping, Laundry and Maintenance	37,020	30,383	8,345	75,748		75,748	2
3	Heat and Other Utilities			23,652	23,652		23,652	3
4	Other (specify):			3,062	3,062		3,062	4
5	**TOTAL General Services**	89,023	104,506	35,455	228,984		228,984	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	194,943	2,538	4,934	202,415		202,415	6
7	Activities and Social Services		12,632	308	12,940	(9,674)	3,266	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	194,943	15,170	5,242	215,355	(9,674)	205,681	9
	C. General Administration							
10	Administrative and Clerical	57,208	5,441	93,914	156,563		156,563	10
11	Marketing Materials, Promotions and Advertising		1,387	18,818	20,205		20,205	11
12	Employee Benefits and Payroll Taxes			52,306	52,306		52,306	12
13	Insurance-Property, Liability and Malpractice			13,818	13,818		13,818	13
14	Other (specify):			58,525	58,525	(58,525)		14
15	**TOTAL General Administration**	57,208	6,828	237,381	301,417	(58,525)	242,892	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	341,174	126,504	278,078	745,756	(68,199)	677,557	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			11,318	11,318		11,318	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			388,031	388,031		388,031	20
21	Rent -- Equipment			5,228	5,228		5,228	21
22	Other (specify):							22
23	**TOTAL Ownership**			404,577	404,577		404,577	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	341,174	126,504	682,655	1,150,333	(68,199)	1,082,134	24

Facility Name: Brookstone Emerald Glen Olny Report Period Beginning 1/1/17 Ending: 12/31/17

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	1.00	21.18	2
3	Certified Nurse Assistants	7.00	9.00	3
4	Activity Director & Assistants	0.50	9.00	4
5	Social Service Workers			5
6	Head Cook	1.00	12.08	6
7	Cook Helpers/Assistants	1.00	10.00	7
8	Dishwashers			8
9	Maintenance Workers	0.50	13.00	9
10	Housekeepers	1.00	11.03	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.00	18.00	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	13	$	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	Senior Lifestyle Corporation	$ 62,400	1
2			2
	Total	$ 62,400	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 Emerald Glen Olny   Report Period Beginning: 1/1/17   Ending: 12/31/17

VIII. OWNERSHIP COSTS

A. Purchase price of land N/A   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	$ 69,692	$ 11,318	$ 11,318	$	5	$ 20,125	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 69,692	$ 11,318	$ 11,318	$		$ 20,125	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 Emerald Glen Olny | Report Period Beginning: 1/1/17 | Ending: 12/31/17

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: WC-Olney EG LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? [ ] YES [X] 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	1998	35	06/01/15	$ 388,031	5		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		35		$ 388,031			7

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

9. Rental amount for movable equipment $ 5,228

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.

Facility Name: Brookstone Emerald Glen Olny | Report Period Beginning: 1/1/17 | Ending: 12/31/17

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (3,594)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	284,446 (85,990)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,171		6
7	Other Prepaid Expenses	3,057		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 211,090	$	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	69,692		16
17	Accumulated Depreciation (book methods)	(20,125)		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)**	$ 49,567	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 260,657	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 36,708	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,678		30
31	Accrued Taxes Payable	318		31
32	Accrued Interest Payable	12,730		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	**Accrued Other**	179,376		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 248,810	$	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**	171,693		42
43	**Deferred Revenues**	77,374		43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 249,067	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 497,877	$	45
46	**TOTAL EQUITY**	$ (237,220)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 260,657	$	47

*(See instructions.)

Facility Name: Brookstone Emerald Glen Olny
Report Period Beginning: 1/1/17 Ending: 12/31/17

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	$ 1,088,599	1
2	Discounts and Allowances	(450)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,088,149	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			15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,088,149	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	228,984	19
20	Health Care/ Personal Care	215,355	20
21	General Administration	301,417	21
	B. Capital Expense		
22	Ownership	404,577	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)**	$ 1,150,333	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (62,184)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (62,184)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 450,482	32
33	Private Pay - Net Inpatient Revenue	637,667	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,088,149	37

Emerald Glen Olney
Adjustments
12/31/2017

CLIENT_ACT	DESC	DEBIT	TB Acct	IL Acct
5565350000	Charitable Contributions	400.00	9760.00	IS 14.3
5790350000	Bad Debt Expense	56,159.59	9765.00	IS 14.3
5890350000	Miscellaneous Expense	1,964.98	9729.20	IS 14.3
5545340000	Television Cost Expense	9,514.19	7126.00	IS 7.2
5551330000	Entertainment Expense	160.00	7210.20	IS 7.3
		68,198.76		