	FOR BHF USE	

LL2

Supportive Living Facility

2020

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2020)

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: 1000016

Facility Name: Brookstone Estates Robinson

Address: 1101 North Monroe St (Number) Robinson (City) 62454 (Zip Code)

County: Crawford

Telephone Number: (618) 544-4663 Fax # ( )

Federal Employer ID Number:

Date Current Owners were Certified: 6/1/2015

Type of Ownership:

	VOLUNTARY, NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
	IRS Exemption Code		Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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 1/1/20 to 12/31/20 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)	Denise A. Leonard, CPA Partner
	(Firm Name & Address)	Plante & Moran, PLLC 1111 Superior Ave Suite 1250 Cleveland, OH 44114
	(Telephone)	(216) 274-6514 Fax # (248) 233-7349

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 Estates Robinson — Report Period Beginning: 1/1/20 Ending: 12/31/20

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	42	Single Unit Apartment	42	15,372	1
2		Double Unit Apartment			2
3		Other			3
4	42	TOTALS	42	15,372	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	8,068	4,713		12,781	5
6	Double Unit					6
7	Other					7
8	TOTALS	8,068	4,713		12,781	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 83.14%

D. Indicate the number of paid bed-hold days the SLF had during this year None Also, indicate the number of unpaid bed-hold days the SLF had during this year. None (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)
None

H. ACCOUNTING BASIS
ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/20 Fiscal Year: 12/31/20
* 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

Facility Name: Brookstone Estates Robinson | Report Period Beginning: 1/1/20 | Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclassifications and Adjustments 5	Adjusted Total 6	
	A. General Services							
1	Dietary and Food Purchase	49,839	89,461		139,300	(14,796)	124,504	1
2	Housekeeping, Laundry and Maintenance	50,235	57,817		108,052		108,052	2
3	Heat and Other Utilities			47,866	47,866		47,866	3
4	Other (specify):			3,899	3,899		3,899	4
5	**TOTAL General Services**	100,074	147,278	51,765	299,117	(14,796)	284,321	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	280,783	30,576	4,233	315,592		315,592	6
7	Activities and Social Services	22,929	1,567	160	24,656		24,656	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	303,712	32,143	4,393	340,248		340,248	9
	C. General Administration							
10	Administrative and Clerical	98,958	16,306	123,567	238,831	(13,077)	225,754	10
11	Marketing Materials, Promotions and Advertising	302	1,285	29,661	31,248		31,248	11
12	Employee Benefits and Payroll Taxes			74,976	74,976		74,976	12
13	Insurance-Property, Liability and Malpractice			25,956	25,956		25,956	13
14	Other (specify):			609	609	(609)		14
15	**TOTAL General Administration**	99,260	17,591	254,769	371,620	(13,686)	357,934	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	503,046	197,012	310,927	1,010,985	(28,482)	982,503	16
	Capital Expenses							
	D. Ownership							
17	Depreciation							17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			481,955	481,955		481,955	20
21	Rent -- Equipment			10,248	10,248		10,248	21
22	Other (specify):							22
23	**TOTAL Ownership**			492,203	492,203		492,203	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	503,046	197,012	803,130	1,503,188	(28,482)	1,474,706	24

Facility Name: Brookstone Estates Robinson
Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.04	$ 20.28	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	8.39	12.11	3
4	Activity Director & Assistants	0.86	12.82	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	1.76	13.61	7
8	Dishwashers			8
9	Maintenance Workers	0.92	14.36	9
10	Housekeepers	0.91	12.02	10
11	Laundry			11
12	Managers (AL Director)	0.96	24.71	12
13	Other Administrative (ED)	0.50	36.70	13
14	Clerical	0.72	40.79	14
15	Marketing	0.01	53.92	15
16	Other (COVID Adj)	0.57	15.47	16
17	Total (lines 1 thru 16)	15.64	$ 15.47	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	N/A			$	1
2					2
3					3
4					4
5					5
			Total	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	SLN Manager SNF, LLC.	$ 74,115	1
2			2
	Total	$ 74,115	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 Estates Robinson Report Period Beginning: 1/1/20 Ending: 12/31/20

VIII. OWNERSHIP COSTS

A. Purchase price of land N/A Year land was acquired N/A

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						$	27	$	$	$	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Phone and Telecom System Upgrade			2019	16,303						6
7	Replace Dry System Air Compressor			2019	2,600						7
8	Water Damage Repairs			2019	3,385						8
9	Air Compressor and Pipe Replacment			2019	8,761						9
10	HVAC Repairs- South Side Unit			2019	6,061						10
11	Fence Replaced With Corridor Carpet			2019	52,063						11
12	Improvements Within Resident Units			2019	3,704						12
13	Grease Trap with Dry Pendants			2019	14,800						13
14											14
15	*Fixed asset balances were transferred to property company, which is an unrelated entity. Historial fixed assets have been kept on this schedule.										15
16	Detail available upon request										16
17	TOTAL (lines 1 thru 16)				$ 107,677	$		$	$	$	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		$ 115,896	$	$			$	18
19								19
20	TOTAL (lines 18 and 19)	$ 115,896	$	$	$		$	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 Estates Robinson
Report Period Beginning: 1/1/20 Ending: 12/31/20

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: WC-Robinson 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	1999	42	6/1/2015	$ 481,955			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		42		$ 481,955			7

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

9. Rental amount for movable equipment $ 10,248

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	IHDA					$	$			$	1
2	IHDA										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 Estates Robinson **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

XI. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	186,580 (52,788)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,833		6
7	Other Prepaid Expenses	3,069		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 156,694	$	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			16
17	Accumulated Depreciation (book methods)			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): CIP	75		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 75	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 156,769	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 58,104	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,238		30
31	Accrued Taxes Payable	47		31
32	Accrued Interest Payable	22,879		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Other	762,080		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 862,348	$	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	998,636		42
43	Deferred Revenues	16,412		43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 1,015,048	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 1,877,396	$	45
46	**TOTAL EQUITY**	$ (1,720,627)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 156,769	$	47

*(See instructions.)

Facility Name: Brookstone Estates Robinson | Report Period Beginning: 1/1/20 | Ending: 12/31/20

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	$ 1,336,698	1
2	Discounts and Allowances	(3,683)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,333,015	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	63,538	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	14,796	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 78,334	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	26	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 26	14
	D. Other Revenue (specify):		
15	**Other Misc. Revenues**	52,022	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 52,022	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,463,397	18

2

	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	299,117	19
20	Health Care/ Personal Care	340,248	20
21	General Administration	371,620	21
	B. Capital Expense		
22	Ownership	492,203	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)**	$ 1,503,188	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (39,791)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (39,791)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 879,205	32
33	Private Pay - Net Inpatient Revenue	453,810	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,333,015	37