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: 1000018

Facility Name: Brookstone Emerld Glen Olney

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	X	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: Anna Kobrzak **Telephone Number:** (312) 673-4360
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 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

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 Emerld Glen Olney 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 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	31	Single Unit Apartment	31	11,346	1
2	4	Double Unit Apartment	4	1,464	2
3		Other		732	3
4	35	TOTALS	35	13,542	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	4,315	3,920		8,235	5
6	Double Unit	850	575		1,425	6
7	Other		732		732	7
8	TOTALS	5,165	5,227		10,392	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 76.74%

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: 12/31/2020 Fiscal Year: 12/31/2020
* 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 Emerld Glen Olney **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				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	54,139	71,556	435	126,130	(16,218)	109,912	1
2	Housekeeping, Laundry and Maintenance	38,643	30,552	6,404	75,599		75,599	2
3	Heat and Other Utilities			40,850	40,850		40,850	3
4	Other (specify):			3,757	3,757		3,757	4
5	**TOTAL General Services**	92,782	102,108	51,446	246,336	(16,218)	230,118	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	222,081	50,890	3,624	276,595		276,595	6
7	Activities and Social Services		2,415	178	2,593	(676)	1,917	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	222,081	53,305	3,802	279,188	(676)	278,512	9
	C. General Administration							
10	Administrative and Clerical	66,913	12,284	110,535	189,732	(6,015)	183,717	10
11	Marketing Materials, Promotions and Advertising	252	1,090	17,667	19,009		19,009	11
12	Employee Benefits and Payroll Taxes			39,215	39,215		39,215	12
13	Insurance-Property, Liability and Malpractice			22,150	22,150		22,150	13
14	Other (specify):			400	400	(400)		14
15	**TOTAL General Administration**	67,165	13,374	189,967	270,506	(6,415)	264,091	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	382,028	168,787	245,215	796,030	(23,309)	772,721	16
	Capital Expenses							
	D. Ownership							
17	Depreciation							17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			420,117	420,117		420,117	20
21	Rent -- Equipment			6,046	6,046		6,046	21
22	Other (specify):							22
23	**TOTAL Ownership**			426,163	426,163		426,163	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	382,028	168,787	671,378	1,222,193	(23,309)	1,198,884	24

Facility Name: Brookstone Emerld Glen Olney 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		$	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	5.30	14.14	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	2.02	12.89	7
8	Dishwashers			8
9	Maintenance Workers	0.34	19.11	9
10	Housekeepers	0.85	14.21	10
11	Laundry			11
12	Managers (AL Director)	0.83	26.04	12
13	Other Administrative (ED)	0.42	42.85	13
14	Clerical	0.44	33.58	14
15	Marketing	0.01	53.92	15
16	Other (COVID Adj)	0.60	17.05	16
17	Total (lines 1 thru 16)	10.81	$ 17.05	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.	$ 60,773	1
2			2
		Total $ 60,773	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

Name 1	City 2

OTHER RELATED BUSINESS ENTITIES

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 [ ] [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 Emerld Glen Olney 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						$		$	$	$	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Phone/Telecommunications System			2019	12,586						6
7	Improvements Within Resident Units			2019	4,183						7
8	Corridor Carpet Replacement			2019	34,208						8
9											9
10											10
11											11
12											12
13	*Fixed asset balances were transferred to property company, which is an unrelated entity. Historial fixed assets have been kept on this schedule.										13
14	Detail available upon request										14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 50,977	$		$	$	$	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	$ 82,406	$	$			$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 82,406	$	$	$		$	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 Emerld Glen Olney 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-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 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	1998	35	6/1/2015	$ 420,117	5		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		35		$ 420,117			7

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

9. Rental amount for movable equipment $ 6,046

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	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 Emerld Glen Olney **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)	41,224 (58,739)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,505		6
7	Other Prepaid Expenses	1,634		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 624	$	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):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 624	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 32,710	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,593		30
31	Accrued Taxes Payable	46		31
32	Accrued Interest Payable	19,820		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Other	690,351		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 753,520	$	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	944,786		42
43	Deferred Revenues	7,361		43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 952,147	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 1,705,667	$	45
46	**TOTAL EQUITY**	$ (1,705,043)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 624	$	47

***(See instructions.)**

Facility Name: Brookstone Emerld Glen Olney **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.)

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,068,258	1
2	Discounts and Allowances	(407)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,067,851	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	79,507	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	16,218	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 95,725	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	**Other Misc Revenues**	6,075	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 6,075	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,169,651	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	246,336	19
20	Health Care/ Personal Care	279,188	20
21	General Administration	270,506	21
	B. Capital Expense		
22	Ownership	426,163	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)**	$ 1,222,193	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (52,542)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (52,542)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 550,182	32
33	Private Pay - Net Inpatient Revenue	517,669	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,067,851	37