

		FOR BHF USE			

LL2

Supportive Living Facility

**2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)**

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.

<p>I. Facility ID Number: <u>100018</u></p> <p>Facility Name: <u>Brookstone Emerald Glen Olney</u></p> <hr/> <p>Address: <u>1301 North East St</u> <u>Olney</u> <u>62450</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Richland</u></p> <p>Telephone Number: (<u>618</u>) <u>395-4663</u> Fax # ()</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>6/1/2015</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact:</p> <p>Name: <u>Anna Kobrzak</u> Telephone Number: (<u>312</u>) <u>673-4360</u></p> <p>Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/18</u> to <u>12/31/18</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Steve Hippel</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Chris Joos Partner</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Plante & Moran, PLLC 250 South High Street, Suite 100</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(614) 222-9040</u> Fax <u>(614) 221-3535</u></td> <td></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Steve Hippel</u>			(Title) <u>Chief Financial Officer</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Chris Joos Partner</u>			(Firm Name & Address) <u>Plante & Moran, PLLC 250 South High Street, Suite 100</u>			(Telephone) <u>(614) 222-9040</u> Fax <u>(614) 221-3535</u>	
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Facility Name Brookstone Emerald Glen Olny

Report Period Beginning: 1/1/18 Ending: 12/31/18

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		131	3
4	35	TOTALS	35	12,906	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	4,783	5,398		10,181	5
6	Double Unit	614	759		1,373	6
7	Other		131		131	7
8	TOTALS	5,397	6,288		11,685	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.54%

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

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)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

* 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? _____
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 principal? _____
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 principal? _____
If no, explain. _____

Facility Name: Brookstone Emerald Glen Olny

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	47,481	48,398	939	96,818		96,818	1
2	Housekeeping, Laundry and Maintenance	37,598	34,108	4,630	76,336		76,336	2
3	Heat and Other Utilities			92,390	92,390		92,390	3
4	Other (specify):			1,803	1,803		1,803	4
5	TOTAL General Services	85,079	82,506	99,762	267,347		267,347	5
B. Health Care and Programs								
6	Health Care/ Personal Care	200,054	4,649	4,918	209,621		209,621	6
7	Activities and Social Services		3,007	153	3,160	(605)	2,555	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	200,054	7,656	5,071	212,781	(605)	212,176	9
C. General Administration								
10	Administrative and Clerical	61,784	3,293	92,672	157,749		157,749	10
11	Marketing Materials, Promotions and Advertising		1,128	8,473	9,601		9,601	11
12	Employee Benefits and Payroll Taxes			42,210	42,210		42,210	12
13	Insurance-Property, Liability and Malpractice			17,734	17,734		17,734	13
14	Other (specify):			335,413	335,413	(335,413)		14
15	TOTAL General Administration	61,784	4,421	496,502	562,707	(335,413)	227,294	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	346,917	94,583	601,335	1,042,835	(336,018)	706,817	16
Capital Expenses								
D. Ownership								
17	Depreciation			15,176	15,176		15,176	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			391,366	391,366		391,366	20
21	Rent -- Equipment			7,467	7,467		7,467	21
22	Other (specify):							22
23	TOTAL Ownership			414,009	414,009		414,009	23
24	GRAND TOTAL (Sum of lines 16 and 23)	346,917	94,583	1,015,344	1,456,844	(336,018)	1,120,826	24

Facility Name: Brookstone Emerald Glen Olny

Report Period Beginning: 1/1/18

Ending: 12/31/18

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.89	\$ 22.19	1
2	Licensed Practical Nurses	0.02	22.28	2
3	Certified Nurse Assistants	7.28	10.44	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	0.95	10.66	7
8	Dishwashers			8
9	Maintenance Workers	0.36	19.26	9
10	Housekeepers	0.88	12.66	10
11	Laundry			11
12	Managers	0.89	14.27	12
13	Other Administrative	0.28	50.79	13
14	Clerical	0.62	25.22	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	12.17	\$	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	\$ 46,681	1
2			2
		Total	3
		\$ 46,681	

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

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).

Facility Name: Brookstone Emerald Glen Olny

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	\$ 82,406	\$ 15,176	\$ 15,176		5	\$ 35,301	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 82,406	\$ 15,176	\$ 15,176			\$ 35,301	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 Olney

Report Period Beginning: 1/1/18

Ending: 12/31/18

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 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	\$ 391,366	5		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		35		\$ 391,366			7

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

9. Rental amount for movable equipment \$ 7,467

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		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			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: 1/1/18

Ending:

12/31/18

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (5,086)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	354,986 (335,840)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,885		6
7	Other Prepaid Expenses	1,997		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 26,942	\$	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	82,408		16
17	Accumulated Depreciation (book methods)	(35,301)		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)	\$ 47,107	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 74,049	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 29,896	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	25,868		30
31	Accrued Taxes Payable	1,156		31
32	Accrued Interest Payable	7,939		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Other	244,454		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 309,313	\$	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	592,465		42
43	Deferred Revenues	41,401		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 633,866	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 943,179	\$	45
46	TOTAL EQUITY	\$ (869,130)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 74,049	\$	47

*(See instructions.)

Facility Name: Brookstone Emerald Glen Olny

Report Period Beginning: 1/1/18

Ending:

12/31/18

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	\$ 1,106,770	1
2	Discounts and Allowances	(268)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,106,502	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)	\$ 1,106,502	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	267,347	19
20	Health Care/ Personal Care	212,781	20
21	General Administration	562,707	21
B. Capital Expense			
22	Ownership	414,009	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)	\$ 1,456,844	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (350,342)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (350,342)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 564,913	32
33	Private Pay - Net Inpatient Revenue	541,589	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,106,502	37

Emerald Glen Olney
Adjustments
12/31/2018

CLIENT_ACT	DESC	DEBIT	TB Acct	IL Acct
5565350000	Charitable Contributions	400.00	9760.00	IS 14.3
5790350000	Bad Debt Expense	262,049.00	9765.00	IS 14.3
5890350000	Miscellaneous Expense	2,660.97	9729.20	IS 14.3
5912346000	Special Events - Corp. Directive	70,303.41	9729.20	IS 14.3
5551330000	Entertainment Expense	605.00	7125.00	IS 7.2
		336,018.38		