

		FOR BHF USE			

LL2

Supportive Living Facility

2011

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2011)

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: 1000008			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER		
Facility Name: <u>Brookstone Midwest Care Fairfield LLC</u>			I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</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.		
Address: <u>315 No. Market St.</u> <u>Fairfield</u> <u>62837</u> NumberCityZip Code			Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.		
County: <u>Wayne</u>					
Telephone Number: (<u>618</u>) <u>842-5875</u> Fax # <u>618 842-5870</u>					
Federal Employer ID Number: _____					
Date Current Owners were Certified: <u>09/01/2009</u>					
Type of Ownership:					
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____			☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other _____		
☐ GOVERNMENTAL ☐ State ☐ County ☐ Other _____					
In the event there are further questions about this report, please contact: Name: <u>Steve Pavlue</u> Telephone Number: (<u>240</u>) <u>841-2921</u> Email Address: <u>spavlue@meridiansenior.com</u>			Officer or Administrator of Provider (Signed) _____ (Type or Print Name) _____ (Title) _____ Paid Preparer (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____		
			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 Midwest Care Fairfield LLC
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Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	46	Single Unit Apartment	46	16,790	1		
2		Double Unit Apartment			2		
3		Other			3		
4	46	TOTALS	46	16,790	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	7,300	8,395		15,695	5
6	Double Unit					6
7	Other					7
8	TOTALS	7,300	8,395		15,695	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.48%

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

ACCUAL	☒	MODIFIED		
CASH*	☐	CASH*	☐	

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

Tax Year: _____ **Fiscal Year:** _____

* 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 Midwest Care Fairfield LLC

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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	14,774	103,769	783	119,326		119,326	1
2	Housekeeping, Laundry and Maintenance	9,620	8,164	1,370	19,154		19,154	2
3	Heat and Other Utilities			65,808	65,808		65,808	3
4	Other (specify):			16,418	16,418		16,418	4
5	TOTAL General Services	24,394	111,933	84,379	220,706		220,706	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	45,719	134		45,853		45,853	6
7	Activities and Social Services		4,896		4,896		4,896	7
8	Other (specify):			5,947	5,947		5,947	8
9	TOTAL Health Care and Programs	45,719	5,031	5,947	56,696		56,696	9
	C. General Administration							
10	Administrative and Clerical	224,221	3,029	139,392	366,643		366,643	10
11	Marketing Materials, Promotions and Advertising			9,871	9,871		9,871	11
12	Employee Benefits and Payroll Taxes			74,554	74,554		74,554	12
13	Insurance-Property, Liability and Malpractice			14,144	14,144		14,144	13
14	Other (specify):							14
15	TOTAL General Administration	224,221	3,029	237,962	465,212		465,212	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	294,333	119,993	328,287	742,614		742,614	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			295	295		295	17
18	Interest			(349)	(349)		(349)	18
19	Real Estate Taxes			17,528	17,528		17,528	19
20	Rent -- Facility and Grounds			597,162	597,162		597,162	20
21	Rent -- Equipment			2,730	2,730		2,730	21
22	Other (specify):							22
23	TOTAL Ownership			617,365	617,365		617,365	23
24	GRAND TOTAL (Sum of lines 16 and 23)	294,333	119,993	945,653	1,359,979		1,359,979	24

Facility Name: Brookstone Midwest Care Fairfield LLC

Report Period Beginning 01/01/2011 Ending: 12/31/2011

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			3
4	Activity Director & Assistants			4
5	Social Service Workers	4	5.78	5
6	Head Cook			6
7	Cook Helpers/Assistants	1	19.47	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	2	7.13	10
11	Laundry			11
12	Managers	2	15.36	12
13	Other Administrative			13
14	Clerical	2	8.90	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	11	\$	17

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).

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	\$	75,003	1
2				2
Total		\$	75,003	3

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	\$	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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 Midwest Care Fairfield LLC

Report Period Beginning: 01/01/2011 Ending: 2/31/2011

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Midwest Care Holdco TRS, 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			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				\$			7

8. Is movable equipment rental included in building rental?

☐ YES ☒ 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	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 Midwest Care Fairfield LLC

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (89,575)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	174,906		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(99)		6
7	Other Prepaid Expenses	(5,986)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(37,808)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 41,438	\$	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	6,247		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(41)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(254)		20
21	Restricted Funds	(378)		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,574	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 47,012	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,774	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,550		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 32,324	\$	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)	\$ 32,324	\$	45
46	TOTAL EQUITY	\$ 14,688	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 47,012	\$	47

*(See instructions.)

Facility Name: Brookstone Midwest Care Fairfield LLC

Report Period Beginning: 01/01/2011

Ending:

12/31/2011

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

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,441,053	1
2	Discounts and Allowances		2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 1,441,053	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
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$	14
	D. Other Revenue (specify):		
15			15
16			16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 1,441,053	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	220,706	19
20	Health Care/ Personal Care	56,696	20
21	General Administration	465,212	21
	B. Capital Expense		
22	Ownership	617,365	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 1,359,979	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ 81,074	29
30	Income Taxes	\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ 81,074	31