

		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: 1000016

Facility Name: Brookstone Midwest Care Robinson LLC

Address: 1101 No. Monroe St. Robinson 62454

County: Crawford

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

Federal Employer ID Number:

Date Current Owners were Certified: 09/01/2009

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL
☐ Charitable Corp.	☐ Individual	☐ State
☐ Trust	☐ Partnership	☐ County
IRS Exemption Code	☐ Corporation	☐ Other
	☐ "Sub-S" Corp.	
	☒ Limited Liability Co.	
	☐ Trust	
	☐ Other	

In the event there are further questions about this report, please contact:

Name: Steve Pavlue Telephone Number: (240) 841-2921

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 01/01/2011 to 12/31/2011 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) _____	(Title) _____
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____	Fax # () _____
	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	

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	42	Single Unit Apartment	42	15,330	1		
2		Double Unit Apartment			2		
3		Other			3		
4	42	TOTALS	42	15,330	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	4,015	10,950		14,965	5
6	Double Unit					6
7	Other					7
8	TOTALS	4,015	10,950		14,965	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.)	97.62%
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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 Robinson 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	23,624	89,486	511	113,622		113,622	1
2	Housekeeping, Laundry and Maintenance	13,329	4,145	1,141	18,615		18,615	2
3	Heat and Other Utilities			49,414	49,414		49,414	3
4	Other (specify):			27,098	27,098		27,098	4
5	TOTAL General Services	36,953	93,631	78,165	208,749		208,749	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	33,637	523		34,160		34,160	6
7	Activities and Social Services	241	5,549		5,790		5,790	7
8	Other (specify):			4,397	4,397		4,397	8
9	TOTAL Health Care and Programs	33,878	6,071	4,397	44,346		44,346	9
	C. General Administration							
10	Administrative and Clerical	245,433	2,013	91,756	339,202		339,202	10
11	Marketing Materials, Promotions and Advertising			13,658	13,658		13,658	11
12	Employee Benefits and Payroll Taxes			92,805	92,805		92,805	12
13	Insurance-Property, Liability and Malpractice			12,911	12,911		12,911	13
14	Other (specify):							14
15	TOTAL General Administration	245,433	2,013	211,129	458,574		458,574	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	316,264	101,716	293,690	711,670		711,670	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			39	39		39	17
18	Interest			(57)	(57)		(57)	18
19	Real Estate Taxes			33,121	33,121		33,121	19
20	Rent -- Facility and Grounds			475,158	475,158		475,158	20
21	Rent -- Equipment			2,798	2,798		2,798	21
22	Other (specify):							22
23	TOTAL Ownership			511,060	511,060		511,060	23
24	GRAND TOTAL (Sum of lines 16 and 23)	316,264	101,716	804,750	1,222,729		1,222,729	24

Facility Name: Brookstone Midwest Care Robinson 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	\$ 25.29	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers	7	10.25	5
6	Head Cook			6
7	Cook Helpers/Assistants	1	11.58	7
8	Dishwashers			8
9	Maintenance Workers	1	12.34	9
10	Housekeepers	1	11.96	10
11	Laundry			11
12	Managers	2	14.82	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	13	\$	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	\$ 68,539	1
2			2
Total		\$ 68,539	3

Facility Name: Brookstone Midwest Care Robinson LLC

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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 Robinson 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 Robinson 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	\$ (36,194)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	95,445		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	126		6
7	Other Prepaid Expenses	(4,931)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	10,322		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 64,768	\$	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	1,098		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	(39)		20
21	Restricted Funds	46,261		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 47,320	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 112,088	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 66,571	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,669		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)	\$ 94,240	\$	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)	\$ 94,240	\$	45
46	TOTAL EQUITY	\$ 17,848	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 112,088	\$	47

*(See instructions.)

Facility Name: Brookstone Midwest Care Robinson 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	1
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,312,498	1
2	Discounts and Allowances		2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 1,312,498	3
	B. Other Operating Revenue		
4	Special Services	3,900	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)	\$ 3,900	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)	\$ 1,316,398	18

	Expenses	Amount	2
	A. Operating Expenses		
19	General Services	208,749	19
20	Health Care/ Personal Care	44,346	20
21	General Administration	458,574	21
	B. Capital Expense		
22	Ownership	511,060	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)	\$ 1,222,729	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ 93,669	29
30	Income Taxes	\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ 93,669	31