

		FOR BHF USE			

LL2

Supportive Living Facility

2013

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2013)

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: 1000024

Facility Name: Brookstone Estates-Vandalia

Address: 1607 West Fillmore Vandalia 64497

County: Fayette

Telephone Number: 618-283-9825 Fax #: 618-283-9926

Federal Employer ID Number:

Date Current Owners were Certified: 9/1/2009

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Bryan Starnes Telephone Number: 828-261-7322
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 1/1/2013 to 12/31/2013 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

Facility Name **Brookstone Estates-Vandalia**

Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	46	Single Unit Apartment	44	16,425	1		
2		Double Unit Apartment			2		
3		Other			3		
4	46	TOTALS	44	16,425	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	8,395	8,030		16,425	5
6	Double Unit					6
7	Other					7
8	TOTALS	8,395	8,030		16,425	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.83%

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 X

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	X	MODIFIED		
CASH*		CASH*		

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

Tax Year: 2013 **Fiscal Year:** 2013

* 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.

STATE OF ILLINOIS

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Facility Name: Brookstone Estates-Vandalia

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	93,841	105,802	14,536	214,178		214,178	1
2	Housekeeping, Laundry and Maintenance	34,285	12,482	10,201	56,969		56,969	2
3	Heat and Other Utilities			46,261	46,261		46,261	3
4	Other (specify):repair& maintenance			9,359	9,359		9,359	4
5	TOTAL General Services	128,126	118,284	80,357	326,766		326,766	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	131,346.47	1,619.59	24,937.65	157,903.71		157,904	6
7	Activities and Social Services	130	301	6,199	6,629.43		6,629	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	130	301	6,199	6,629		164,533	9
	C. General Administration							
10	Administrative and Clerical	64,805	7,483	47,143	119,432		119,432	10
11	Marketing Materials, Promotions and Advertising			11,734	11,734		11,734	11
12	Employee Benefits and Payroll Taxes			34,732	34,732		34,732	12
13	Insurance-Property, Liability and Malpractice			29,439	29,439		29,439	13
14	Other (specify):management fee			77,086	77,086		77,086	14
15	TOTAL General Administration	64,805	7,483	200,134	272,423		272,423	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	193,061	126,068	286,689	605,818		763,722	16
	Capital Expenses							
	D. Ownership							
17	Depreciation						3,434	17
18	Interest							18
19	Real Estate Taxes						71,870	19
20	Rent -- Facility and Grounds						411,616	20
21	Rent -- Equipment						1,563	21
22	Other (specify):							22
23	TOTAL Ownership						488,483	23
24	GRAND TOTAL (Sum of lines 16 and 23)	193,061	126,068	286,689	605,818		1,252,205	24

Facility Name: Brookstone Estates-Vandalia

Report Period Beginning 1/1/2013 Ending: 12/31/2013

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	1	21.83	2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants	1	12.83	4
5	Social Service Workers			5
6	Head Cook	1	17.34	6
7	Cook Helpers/Assistants	2	8.71	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	8.76	10
11	Laundry			11
12	Managers	1	17.34	12
13	Other Administrative	4	9.19	13
14	Clerical			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	\$	77,086	1
2				2
Total		\$	77,086	3

Facility Name: Brookstone Estates-Vandalia

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	\$ 3165.61	\$ 584	\$ 584	\$	5	\$ 584	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 3,166	\$ 584	\$ 584	\$		\$ 584	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	Furniture & other improvement-2013	\$ 17,029	\$ 2,885	\$ 2,885	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 17,029	\$ 2,885	\$ 2,885	24

Facility Name: Brookstone Estates-Vandalia

Report Period Beginning: 1/1/2013

Ending: 2/31/2013

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: NRF Healthcare 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		8. Is movable equipment rental included in building rental?
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*		☐ YES ☒ X
3	Original Building		46	4/1/2011 / /	\$ 418,275.00	10		3	
4	Additions			/ /				4	
5				/ /				5	
6				/ /				6	
7	TOTAL				\$			7	

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.

STATE OF ILLINOIS

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Facility Name: Brookstone Estates-Vandalia

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 915,359	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	216,491		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,506		6
7	Other Prepaid Expenses	2,541		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,139,897	\$	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	17,029		15
16	Equipment, at Historical Cost	3,166		16
17	Accumulated Depreciation (book methods)	(3,469)		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)	\$ 16,726	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,156,623	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 95,814	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	35,210		29
30	Accrued Salaries Payable	13,458		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation	2,906		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)	\$ 147,389	\$	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)	\$ 147,389	\$	45
46	TOTAL EQUITY	\$ 1,009,234	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,156,623	\$	47

*(See instructions.)

Facility Name: Brookstone Estates-Vandalia

Report Period Beginning: 1/1/2013

Ending:

12/31/2013

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	\$ 1,515,612	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,515,612	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services	34,714	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)	\$ 34,714	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	7,459	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 7,459	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)	\$ 1,557,785	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	326,766	19
20	Health Care/ Personal Care	164,533	20
21	General Administration	345,857	21
	B. Capital Expense		
22	Ownership	415,049	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)	\$ 1,252,206	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 305,580	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 305,580	31

