

		FOR BHF USE			

LL2

Supportive Living Facility

2014

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2014)

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 Estates Robinson

Address: 1101 North Monroe St Robinson 62454

County: Crawford

Telephone Number: (618-544-4663 Fax # 217-892-2128

Federal Employer ID Number:

Date Current Owners were Certified: 09/01/2009

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2014 to 09/30/2014 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)

(Type or Print Name)

(Title)

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

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

Name: Bryan Starnes Telephone Number: 838-261-7322

Email Address: bstarnes@meridiansenior.com

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

HFS 3745C (N-4-05)

IL478-2471

Facility Name **Brooks Brookstone Midwest Care Robinson LLC**

Report Period Beginning: 01/01/2014 Ending: 09/30/2014

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units

NA

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	11,466	1		
2		Double Unit Apartment			2		
3		Other			3		
4	42	TOTALS	42	11,466	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	3,003	8,030		11,033	5
6	Double Unit					6
7	Other					7
8	TOTALS	3,003	8,030		11,033	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) **96.22%**

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

MODIFIED	
ACCUAL	CASH*

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

Tax Year: 2014 **Fiscal Year:** 2014

* 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.

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	39,353	57,492	9,620	106,465		106,465	1
2	Housekeeping, Laundry and Maintenance	4,088	11,937	3,474	19,499		19,499	2
3	Heat and Other Utilities			34,582	34,582		34,582	3
4	Other (specify):repair & maintenance			10,775	10,775		10,775	4
5	TOTAL General Services	43,441	69,429	58,452	171,321		171,321	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	131,630	789	23,316	155,735		155,735	6
7	Activities and Social Services		1,933	5,426	7,359		7,359	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	131,630	2,721	28,743	163,094		163,094	9
	C. General Administration							
10	Administrative and Clerical	67,579	2,809	29,251	99,640		99,640	10
11	Marketing Materials, Promotions and Advertising			14,345	14,345		14,345	11
12	Employee Benefits and Payroll Taxes			38,685	38,685		38,685	12
13	Insurance-Property, Liability and Malpractice			25,341	25,341		25,341	13
14	Other (specify): management fee			50,180	50,180		50,180	14
15	TOTAL General Administration	67,579	2,809	157,803	228,191		228,191	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	242,650	74,959	244,997	562,606		562,606	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			5,307	5,307		5,307	17
18	Interest							18
19	Real Estate Taxes			27,173	27,173		27,173	19
20	Rent -- Facility and Grounds			323,050	323,050		323,050	20
21	Rent -- Equipment			4,905	4,905		4,905	21
22	Other (specify):							22
23	TOTAL Ownership			360,435	360,435		360,435	23
24	GRAND TOTAL (Sum of lines 16 and 23)	242,650	74,959	605,432	923,041		923,041	24

Facility Name: Brookstone Midwest Care Robinson LLC

Report Period Beginning 01/01/2014 Ending: 09/30/2014

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	23.85	2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants	1	12.87	4
5	Social Service Workers			5
6	Head Cook	2	12.55	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	8.75	10
11	Laundry			11
12	Managers	1	16.02	12
13	Other Administrative	7	9.36	13
14	Clerical			14
15	Marketing	1	21.63	15
16	Other			16
17	Total (lines 1 thru 16)	14	\$	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	\$	50,180	1
2				2
Total		\$	50,180	3

Facility Name: Broo Brookstone Midwest Care Robinson LLC

Report Period Beginning: 01/01/2014

Ending: 09/30/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land NA 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	\$	13,431	\$ 1,569	\$ ####		5	\$ 5,878	18
19	Vehicles								19
20	TOTAL (lines 18 and 19)	\$	13,431	\$ 1,569	\$	\$		\$ 5,878	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 and Other Improvement - 2012	\$ 4,804	\$ \$ 1,001	\$ 2,463	21
22	Furniture and Other Improvement - 2013	11,388	1,468	3,526	22
23	Furniture and Other Improvement - 2014	9,389	772	772	23
24	TOTALS (lines 21, 22 and 23)	\$ 25,581	\$ 3,241	\$ 6,761	24

Facility Name: Brookstone Midwest Care Robinson LLC

Report Period Beginning: 01/01/2014 Ending: 09/30/2014

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 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		42	04/01/2011	\$ 546,000	10		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		42		\$ 546,000			7

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

9. Rental amount for movable equipment \$ NA

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

Page 7

Facility Name: Brookstone Midwest Care Robinson LLC

Report Period Beginning: 01/01/2014

Ending: 09/30/2014

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2014

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (154,793)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	155,565		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,502		6
7	Other Prepaid Expenses	3,269		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 13,544	\$	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	18,657		15
16	Equipment, at Historical Cost	20,355		16
17	Accumulated Depreciation (book methods)	(12,639)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	115,487		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 141,860	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 155,403	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 128,028	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	525		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,648		30
31	Accrued Taxes Payable	(29,598)		31
32	Accrued Interest Payable			32
33	Deferred Compensation	(20,516)		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Deferred lease payment	29,770		35
36	Deferred Lease Payment	15,002		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 137,859	\$	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)	\$ 137,859	\$	45
46	TOTAL EQUITY	\$ 17,544	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 155,403	\$	47

*(See instructions.)

Facility Name: Brookstone Midwest Care Robinson LLCEnding: 09/30/2014**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	\$ 989,976	1
2	Discounts and Allowances	(3,395)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 986,581	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	54	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 54	14
	D. Other Revenue (specify):		
15	pet fee	310	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 310	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 986,945	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	171,321	19
20	Health Care/ Personal Care	163,094	20
21	General Administration	228,191	21
	B. Capital Expense		
22	Ownership	360,436	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)	\$ 923,042	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 63,903	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 63,903	31

