

		FOR BHF USE			

LL2

Supportive Living Facility

2015

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2015)

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 # ()

Federal Employer ID Number:

Date Current Owners were Certified: 06/01/15

Type of Ownership:

<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	

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

Name: Leticia Gonzalez Telephone Number: (312) 673-4360

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 6/1/2015 to 12/31/2015 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)	Jeremy Zednick	
	(Title)	VP of Accounting	
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)	Chris Joos Partner	
	(Firm Name & Address)	Plante Moran 65 East State Street, Suite 600, Columbus, OH 43215	
	(Telephone)	(614) 849-3000 Fax 248-233-8811	
	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 Robinson****Report Period Beginning: 6/1/2015 Ending: 12/31/2015**

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	8,988	1		
2		Double Unit Apartment			2		
3		Other			3		
4	42	TOTALS	42	8,988	4		

B. Census-For the entire report period.

	1 Type of Unit	2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
Resident Days by Unit and Primary Source of Payment						
5	Single Unit	1,911	6,925		8,836	5
6	Double Unit					6
7	Other					7
8	TOTALS	1,911	6,925		8,836	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.31%

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*	<input type="checkbox"/>	CASH*	<input type="checkbox"/>

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

Tax Year: 12/31/15 **Fiscal Year:** 12/31/15

* 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 Robinson

Report Period Beginning:

6/1/2015

Ending:

12/31/2015

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	39,021	5,580	48,577	93,178		93,178	1
2	Housekeeping, Laundry and Maintenance	14,315		18,714	33,029		33,029	2
3	Heat and Other Utilities			32,092	32,092		32,092	3
4	Other (specify): Waste Removal, TV cost			2,912	2,912	(2,535)	377	4
5	TOTAL General Services	53,336	5,580	102,295	161,211	(2,535)	158,676	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	125,145			125,145		125,145	6
7	Activities and Social Services	5,297		4,890	10,187		10,187	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	130,442		4,890	135,332		135,332	9
	C. General Administration							
10	Administrative and Clerical	41,043	4,743	69,943	115,729		115,729	10
11	Marketing Materials, Promotions and Advertising	424		19,459	19,883		19,883	11
12	Employee Benefits and Payroll Taxes			34,915	34,915		34,915	12
13	Insurance-Property, Liability and Malpractice			13,165	13,165		13,165	13
14	Other (specify): Bad Debt			2,562	2,562	(2,562)		14
15	TOTAL General Administration	41,467	4,743	140,044	186,254	(2,562)	183,692	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	225,245	10,323	247,229	482,797	(5,097)	477,700	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			1,631	1,631		1,631	17
18	Interest							18
19	Real Estate Taxes			34,454	34,454		34,454	19
20	Rent -- Facility and Grounds			259,196	259,196		259,196	20
21	Rent -- Equipment			1,707	1,707		1,707	21
22	Other (specify):							22
23	TOTAL Ownership			296,988	296,988		296,988	23
24	GRAND TOTAL (Sum of lines 16 and 23)	225,245	10,323	544,217	779,785	(5,097)	774,688	24

Facility Name: Brookstone Estates Robinson

Report Period Beginning 6/1/2015 Ending: 12/31/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 23.76	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	8	9.27	3
4	Activity Director & Assistants	0	9.00	4
5	Social Service Workers			5
6	Head Cook	1	12.86	6
7	Cook Helpers/Assistants	2	9.95	7
8	Dishwashers			8
9	Maintenance Workers	0	9.82	9
10	Housekeepers	1	8.86	10
11	Laundry			11
12	Managers	2	16.30	12
13	Other Administrative	0	15.27	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	16	\$	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	Senior Lifestyle Corporation	\$ 44,599	1
2			2
Total		\$ 44,599	3

Facility Name: Brookstone Estates Robinson

Report Period Beginning:

6/1/2015

Ending:

12/31/2015

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	Monument Signage		2015	2015	1,049	19	27	19		19	6
7	Leasehold Improvement		2015	2015	1,812	5	27	5		5	7
8	Kitchen Renovation		2015	2015	19,779	60	27	60		60	8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 22,640	\$ 84		\$ 84	\$	\$ 84	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	\$ 23,068	\$ 1,547	\$ 1,547	\$	5	\$ 1,547	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 23,068	\$ 1,547	\$ 1,547	\$		\$ 1,547	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 Estates Robinson

Report Period Beginning: 6/1/2015

Ending: 2/31/2015

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: WC-Robinson 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	1999	42	06/01/15	\$ 259,196	5		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		42		\$ 259,196			7

8. Is movable equipment rental included in building rental?

☒ YES

☐ NO

9. Rental amount for movable equipment \$ 1,707

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.

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Facility Name: Brookstone Estates Robinson

Report Period Beginning: 6/1/2015

Ending: 12/31/2015

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,008	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	116,650 (23,493)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(3,780)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 93,385	\$	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	22,640		15
16	Equipment, at Historical Cost	23,068		16
17	Accumulated Depreciation (book methods)	(1,631)		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): Deposit	1,798		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 45,875	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 139,260	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 31,202	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,182		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,433		30
31	Accrued Taxes Payable	59,105		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Rent	15,580		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 145,502	\$	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 Loan	(23,729)		42
43	Deferred Revenue	3,523		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ (20,206)	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 125,296	\$	45
46	TOTAL EQUITY	\$ 13,964	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 139,260	\$	47

*(See instructions.)

Facility Name: Brookstone Estates Robinson

Report Period Beginning: 6/1/2015

Ending:

12/31/2015

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	\$ 767,251	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 767,251	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)	\$ 767,251	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	158,676	19
20	Health Care/ Personal Care	135,332	20
21	General Administration	183,692	21
	B. Capital Expense		
22	Ownership	296,988	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify): Non-allowable Cost	5,097	25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 779,785	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (12,534)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (12,534)	31

Brookstone Estates Robinson
Automobile Schedule
2015

Year	Make	Model	Lease Costs
N/A			

Brookstone Estates Robinson
12/31/2015
Non Allowable Cost Adjustments and Reclasses

NON ALLOWABLE COST ADJUSTMENTS

TB Acct	Client Acct	Description	Amount	Part IV Line
9765.00	5790350000	Bad Debt Expense	3,842.23	IS 14.3
9729.20	5890350000	Miscellaneous Expense	1,463.81	IS 14.3
9729.20	5912346000	Special Events - Corp. Directive	(1,559.53)	IS 14.3
9729.20	AJE2A	Misc Expense Offset	(1,184.36)	IS 14.3
7126.00	5545340000	Television Cost Expense	2,535.22	IS 3.3
			<u>5,097.37</u>	

RECLASSES

None