FOR BHF USE

LL2

Supportive Living Facility

2010

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)

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 of Robinson

Address: 1101 North Monroe Street (Number) Robinson (City) 62454 (Zip Code)

County: Crawford

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

Federal Employer ID Number:

Date Current Owners were Certified: 9/1/2009

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Pavlue **Telephone Number:** (828) 261-7337
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 1/1/10 to 12/31/10 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) Steve Pavlue, CPA
(Title) EVP, Chief Accounting Officer

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 of Robinson Report Period Beginning: 1/1/10 Ending: 12/31/10

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	42	Single Unit Apartment	42	15,330	1
2		Double Unit Apartment			2
3		Other		554	3
4	42	TOTALS	42	15,884	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	6,617	9,191		15,808	5
6	Double Unit					6
7	Other					7
8	TOTALS	6,617	9,191		15,808	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.52%

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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS
ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] 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 Estates of Robinson **Report Period Beginning: 1/1/10 Ending: 12/31/10**

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	63,995	75,625		139,620		139,620	1
2	Housekeeping, Laundry and Maintenance	17,617	10,746	17,794	46,157		46,157	2
3	Heat and Other Utilities			66,914	66,914	(8,479)	58,435	3
4	Other (specify): Waste Removal			2,495	2,495		2,495	4
5	**TOTAL General Services**	81,612	86,371	87,203	255,186	(8,479)	246,707	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	160,533	916		161,449		161,449	6
7	Activities and Social Services		2,046		2,046		2,046	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	160,533	2,962		163,495		163,495	9
	C. General Administration							
10	Administrative and Clerical	80,606	9,282	20,519	110,407		110,407	10
11	Marketing Materials, Promotions and Advertising			12,468	12,468		12,468	11
12	Employee Benefits and Payroll Taxes			115,739	115,739		115,739	12
13	Insurance-Property, Liability and Malpractice			10,393	10,393		10,393	13
14	Other (specify): PY Adj,Internet, Interest Income			(5,204)	(5,204)		(5,204)	14
15	**TOTAL General Administration**	80,606	9,282	153,915	243,803		243,803	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	322,751	98,615	241,118	662,484	(8,479)	654,005	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			4,655	4,655		4,655	17
18	Interest			928	928		928	18
19	Real Estate Taxes			3,358	3,358		3,358	19
20	Rent -- Facility and Grounds			434,578	434,578		434,578	20
21	Rent -- Equipment			609	609		609	21
22	Other (specify): Mgmt Fees, Income Tax, Tax Penalty			155,155	155,155	(85,556)	69,599	22
23	**TOTAL Ownership**			599,282	599,282	(85,556)	513,726	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	322,751	98,615	840,400	1,261,767	(94,035)	1,167,732	24

Facility Name: Brookstone Estates of Robinson Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.9	$ 21.20	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers	8.5	8.80	5
6	Head Cook			6
7	Cook Helpers/Assistants	3.5	11.72	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1.0	9.36	10
11	Laundry			11
12	Managers	2.0	26.97	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	15.9	$	17

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	Good Neighbor Care LLC (JAN - JUL)	$ 37,995	1
2	Meridian Senior Living (AUG - DEC)	31,603	2
	Total	$ 69,598	3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES				OTHER RELATED BUSINESS ENTITIES					
Name	1	City	2	Name	3	City	4	Type of Busines	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 [X]
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 [X]
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).

Facility Name: Brookstone Estates of Robinson Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Estates of Robinson **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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? [X] 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			/ /	$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				$			7

8. Is movable equipment rental included in building rental? [ ] YES [X] 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 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	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 Estates of Robinson **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/10 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,412	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	30,743		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,978		6
7	Other Prepaid Expenses	31,891		7
8	Accounts Receivable (owners or related parties)	224,462		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 296,485	$	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			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			20
21	Restricted Funds	75,404		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 75,404	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 371,889	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,290		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,048		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	**Property Taxes Payable**	19,666		35
36	**Accrued Expenses**	7,026		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 130,030	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	3,771		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)**	$ 3,771	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 133,801	$	45
46	**TOTAL EQUITY**	$ 238,088	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 371,889	$	47

***(See instructions.)**

Facility Name: Brookstone Estates of Robinson **Report Period Beginning: 1/1/10 Ending: 12/31/10**

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

	Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,268,395	1
2	Discounts and Allowances	(2,784)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,265,612	3
	B. Other Operating Revenue		
4	Special Services (Move-in Fees)	13,000	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)**	$ 13,000	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	**Food Stamp Revenue**	26,757	15
16	**Miscellaneous**	926	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 27,683	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,306,295	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	246,707	19
20	Health Care/ Personal Care	163,495	20
21	General Administration	243,803	21
	B. Capital Expense		
22	Ownership	513,726	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)**	$ 1,167,732	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 138,563	29
30	**Income Taxes**	$ 85,556	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 53,007	31

000	112	Utilities - elec	48,957.95		
000	112	Utilities - gas	3,659.20		
000	112	Utilities - wat	5,818.16		
			66,914.25	3-3	Heat and Other Utilities
000	112	Utilities - cab	8,478.94-	3-5	Adjust out Cable
000	112	Utilities - garb	2,494.91	4	Other
000	112	Interest Incor	62.94-		
000	112	Utilities - inte	977.38		
000	112	Other Income	6,118.35-		
			5,203.91-	14	Other
000	112	Management	69,598.43		
000	112	Income Tax E	81,960.62		
000	112	Tax Penalties	3,595.36		
000	112	Gain/(Loss) c	0.13		
			155,154.54	22	Other (specify):
000	112	Income Tax E	81,960.62-		
000	112	Tax Penalties	427.45-		
			82,388.07-	22-5	Adjust out Income Tax & Penalty