

		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.

<p>I. Facility ID Number: <u>1000070</u></p> <p>Facility Name: <u>Brookstone Estates Harrisbrg</u></p> <p>Address: <u>165 Ron Morse Drive</u> <u>Harrisburg</u> <u>62946</u> <small>Number City Zip Code</small></p> <p>County: <u>Saline</u></p> <p>Telephone Number: (<u>618</u>) <u>253-5870</u> Fax # ()</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>06/01/15</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Leticia U Gonzalez</u> Telephone Number: (<u>312</u>) <u>673-4360</u> Email Address: _____</p>	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/15</u> to <u>12/31/15</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>Jeremy Zednick</u> (Title) <u>VP of Accounting</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Print Name and Title) <u>Chris Joos Partner</u> (Firm Name & Address) <u>Plante Moran 65 E. State Street, Suite 600 Columbus, Ohio 43215</u> (Telephone) <u>(614) 849-3000</u> Fax <u>(614) 221-3535</u> </td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Jeremy Zednick</u> (Title) <u>VP of Accounting</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Chris Joos Partner</u> (Firm Name & Address) <u>Plante Moran 65 E. State Street, Suite 600 Columbus, Ohio 43215</u> (Telephone) <u>(614) 849-3000</u> Fax <u>(614) 221-3535</u>
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Facility Name: Brookstone Estates Harrisbrg

Report Period Beginning:

06/01/15

Ending:

12/31/15

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	57,979	9,405	65,953	133,337		133,337	1
2	Housekeeping, Laundry and Maintenance	19,340		29,808	49,148		49,148	2
3	Heat and Other Utilities			49,544	49,544	(5,101)	44,443	3
4	Other (specify): Waste removal			714	714		714	4
5	TOTAL General Services	77,319	9,405	146,019	232,743	(5,101)	227,642	5
B. Health Care and Programs								
6	Health Care/ Personal Care	97,913	567	2,208	100,688		100,688	6
7	Activities and Social Services	14,734		2,351	17,085		17,085	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	112,647	567	4,559	117,773		117,773	9
C. General Administration								
10	Administrative and Clerical	25,053	8,137	74,197	107,387		107,387	10
11	Marketing Materials, Promotions and Advertising	462		12,787	13,249		13,249	11
12	Employee Benefits and Payroll Taxes			39,915	39,915		39,915	12
13	Insurance-Property, Liability and Malpractice			12,199	12,199		12,199	13
14	Other (specify): Bad Debt and Misc Exp			340	340	(340)		14
15	TOTAL General Administration	25,515	8,137	139,438	173,090	(340)	172,750	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	215,481	18,109	290,016	523,606	(5,441)	518,165	16
Capital Expenses								
D. Ownership								
17	Depreciation			2,854	2,854		2,854	17
18	Interest							18
19	Real Estate Taxes			89,948	89,948		89,948	19
20	Rent -- Facility and Grounds			402,380	402,380		402,380	20
21	Rent -- Equipment			1,057	1,057		1,057	21
22	Other (specify):							22
23	TOTAL Ownership			496,239	496,239		496,239	23
24	GRAND TOTAL (Sum of lines 16 and 23)	215,481	18,109	786,255	1,019,845	(5,441)	1,014,404	24

Facility Name: Brookstone Estates Harrisbrg

Report Period Beginning 06/01/15

Ending: 12/31/15

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 21.73	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6	9.25	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	10.60	6
7	Cook Helpers/Assistants	4	9.00	7
8	Dishwashers			8
9	Maintenance Workers	1	9.93	9
10	Housekeepers	1	8.67	10
11	Laundry			11
12	Managers	2	14.74	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	15	\$	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	Senior Lifestyle Corporation	\$ 55,796	1	
2			2	
		Total	\$ 55,796	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

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).

Facility Name: Brookstone Estates Harrisbrg

Report Period Beginning:

06/01/15

Ending:

12/31/15

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	Nurse Call System		2015	2015	29,968	272	27	272		272	6
7	Apartment 12 Repairs		2015	2015	5,002	61	27	61		61	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)				\$ 34,970	\$ 333		\$ 333	\$	\$ 333	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	\$ 39,637	\$ 2,521	\$ 2,521		5 - 7	\$ 2,521	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)		\$ 39,637	\$ 2,521	\$ 2,521		\$ 2,521	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 Harrisbrg

Report Period Beginning: 06/01/15

Ending: 12/31/15

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: WC-Harrisburg 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	2005	46	06/01/15	\$ 402,380	5		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		46		\$ 402,380			7

8. Is movable equipment rental included in building rental?

YES NO

9. Rental amount for movable equipment \$ 1,057

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**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 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 Estates Harrisbrg

Report Period Beginning: 06/01/15

Ending:

12/31/15

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 40,079	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	142,940 (10,659)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,587		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)	\$ 175,947	\$	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	34,970		15
16	Equipment, at Historical Cost	39,637		16
17	Accumulated Depreciation (book methods)	(2,854)		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): Deposits	1,986		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 73,739	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 249,686	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 7,173	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,634		30
31	Accrued Taxes Payable	157,947		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Rent	186,997		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 386,751	\$	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	(81,515)		42
43	Deferred Revenue	14,193		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ (67,322)	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 319,429	\$	45
46	TOTAL EQUITY	\$ (69,743)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 249,686	\$	47

*(See instructions.)

Facility Name: Brookstone Estates Harrisbrg

Report Period Beginning: 06/01/15

Ending:

12/31/15

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 937,601	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 937,601	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)	\$ 937,601	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	227,642	19
20	Health Care/ Personal Care	117,773	20
21	General Administration	172,750	21
B. Capital Expense			
22	Ownership	496,239	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify): Non-allowable costs	5,441	25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 1,019,845	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (82,244)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (82,244)	31

Brookstone Estates of Harrisburg
Automobile Schedule
2015

<u>Year</u>	<u>Make</u>	<u>Model</u>	<u>Lease Costs</u>
N/A			

Brookstone Estates of Harrisburg

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	4,701.08	IS 14.3
9729.20	5890350000	Miscellaneous Expense	1,790.91	IS 14.3
9729.20	5912346000	Special Events - Corp. Directive	(4,791.95)	IS 14.3
9729.20	AJE2A		(1,460.17)	IS 14.3
9730.00	AJE2A		100.00	IS 14.3
7126.00	5545340000	Television Cost Expense	<u>5,100.68</u>	IS 3.3
			5,440.55	

RECLASSES

None