

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2017  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2017)**

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><b>I. Facility ID Number:</b> <u>100008</u></p> <p><b>Facility Name:</b> <u>Brookstone Estates Fairfield</u></p> <hr/> <p><b>Address:</b> <u>315 North Market</u> <u>Fairfield</u> <u>62837</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>Wayne</u></p> <p><b>Telephone Number:</b> ( <u>618</u> ) <u>842-5875</u> Fax # ( )</p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>06/01/15</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>Anna Kobrzak</u> <b>Telephone Number:</b> ( <u>312</u> ) <u>673-4360</u></p> <p><b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/17</u> to <u>12/31/17</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%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Steve Hippel</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> <td></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Chris Joos Partner</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Plante &amp; Moran, PLLC 250 South High Street, Suite 100</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(614) 222-9040</u> Fax <u>(614) 221-3535</u></td> <td></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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>Steve Hippel</u>			(Title) <u>Chief Financial Officer</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____		(Print Name and Title) <u>Chris Joos Partner</u>			(Firm Name & Address) <u>Plante &amp; Moran, PLLC 250 South High Street, Suite 100</u>			(Telephone) <u>(614) 222-9040</u> Fax <u>(614) 221-3535</u>	
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Facility Name Brookstone Estates Fairfield

Report Period Beginning: 1/1/17 Ending: 12/31/17

**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	39	Single Unit Apartment	39 #	14,235	1
2	7	Double Unit Apartment	7 #	2,555	2
3		Other			3
4	46	TOTALS	46	16,790	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	7,665	6,570		14,235	5
6	Double Unit		2,095		2,095	6
7	Other					7
8	TOTALS	7,665	8,665		16,330	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.26%

D. Indicate the number of paid bed-hold days the SLF had during this year

75 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)

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H. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

\* 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 Fairfield

Report Period Beginning:

1/1/17

Ending:

12/31/17

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	50,296	59,947	275	110,518		110,518	1
2	Housekeeping, Laundry and Maintenance	39,598	35,496	5,448	80,542		80,542	2
3	Heat and Other Utilities			75,860	75,860		75,860	3
4	Other (specify): Trash Removal			3,965	3,965		3,965	4
5	<b>TOTAL General Services</b>	<b>89,894</b>	<b>95,443</b>	<b>85,548</b>	<b>270,885</b>		<b>270,885</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	218,635		4,512	223,147		223,147	6
7	Activities and Social Services	5,713	12,823	1,348	19,884	(9,898)	9,986	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>224,348</b>	<b>12,823</b>	<b>5,860</b>	<b>243,031</b>	<b>(9,898)</b>	<b>233,133</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	101,113	8,009	138,510	247,632		247,632	10
11	Marketing Materials, Promotions and Advertising		1,231	20,965	22,196		22,196	11
12	Employee Benefits and Payroll Taxes			79,281	79,281		79,281	12
13	Insurance-Property, Liability and Malpractice			17,960	17,960		17,960	13
14	Other (specify):			33,145	33,145	(33,145)		14
15	<b>TOTAL General Administration</b>	<b>101,113</b>	<b>9,240</b>	<b>289,861</b>	<b>400,214</b>	<b>(33,145)</b>	<b>367,069</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>415,355</b>	<b>117,506</b>	<b>381,269</b>	<b>914,130</b>	<b>(43,043)</b>	<b>871,087</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			7,738	7,738		7,738	17
18	Interest							18
19	Real Estate Taxes			761	761		761	19
20	Rent -- Facility and Grounds			650,427	650,427		650,427	20
21	Rent -- Equipment			94	94		94	21
22	Other (specify): Other Taxes							22
23	<b>TOTAL Ownership</b>			<b>659,020</b>	<b>659,020</b>		<b>659,020</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>415,355</b>	<b>117,506</b>	<b>1,040,289</b>	<b>1,573,150</b>	<b>(43,043)</b>	<b>1,530,107</b>	<b>24</b>

Facility Name: Brookstone Estates Fairfield

Report Period Beginning: 1/1/17 Ending: 12/31/17

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.50	\$ 19.72	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	8.50	10.00	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1.00	13.00	6
7	Cook Helpers/Assistants			7
8	Dishwashers	2.00	9.50	8
9	Maintenance Workers	1.00	11.50	9
10	Housekeepers	1.00	10.25	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.00	23.50	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>16</b>	<b>\$</b>	<b>17</b>

**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
				<b>Total</b>	<b>6</b>
				\$	

**VI. (B) Management fees paid to unrelated parties**

		Amount of Fee	
1	Senior Lifestyle Corporation	\$ 109,716	1
2			2
		<b>Total</b>	<b>3</b>
		\$ 109,716	

**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 Fairfield

Report Period Beginning:

1/1/17

Ending:

12/31/17

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
	<b>Improvement Type</b>										
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	<b>TOTAL (lines 1 thru 16)</b>				\$	\$		\$	\$	\$	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	\$ 81,873	\$ 7,738	\$ 7,738		5-7	\$ 12,827	18
19	Vehicles							19
20	<b>TOTAL (lines 18 and 19)</b>	\$ 81,873	\$ 7,738	\$ 7,738			\$ 12,827	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	<b>TOTALS (lines 21, 22 and 23)</b>	\$	\$	\$	24

Facility Name: Brookstone Estates Fairfield

Report Period Beginning: 1/1/17

Ending: 12/31/17

**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: WC-Fairfield 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	1997	46	06/01/15	\$ 650,427	5		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	<b>TOTAL</b>		46		\$ 650,427			7

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

9. Rental amount for movable equipment \$ 94

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				
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1					/ /	\$	\$	/ /		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
	<b>Working Capital</b>										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$	\$			\$	7
	<b>B. Non-Facility Related</b>										
8					/ /			/ /			8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	\$			\$	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 Fairfield

Report Period Beginning: 1/1/17

Ending:

12/31/17

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (4,017)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	214,838 (44,980)		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,178		6
7	Other Prepaid Expenses	7,517		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 190,536</b>	<b>\$</b>	<b>10</b>
	<b>B. Long-Term Assets</b>			
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	81,873		16
17	Accumulated Depreciation (book methods)	(12,827)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 69,046</b>	<b>\$</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 259,582</b>	<b>\$</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 23,093	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,202		30
31	Accrued Taxes Payable	147		31
32	Accrued Interest Payable	16,601		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	Accrued Other	261,463		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	<b>\$ 345,506</b>	<b>\$</b>	<b>37</b>
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42	Intercompany	379,881		42
43	Deferred Revenues	23,855		43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	<b>\$ 403,736</b>	<b>\$</b>	<b>44</b>
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	<b>\$ 749,242</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL EQUITY</b>	<b>\$ (489,660)</b>	<b>\$</b>	<b>46</b>
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	<b>\$ 259,582</b>	<b>\$</b>	<b>47</b>

\*(See instructions.)

Facility Name: Brookstone Estates Fairfield

Report Period Beginning: 1/1/17

Ending:

12/31/17

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

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 1,623,977	1
2	Discounts and Allowances	(498)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 1,623,479</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
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	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 1,623,479</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	270,885	19
20	Health Care/ Personal Care	243,031	20
21	General Administration	400,214	21
<b>B. Capital Expense</b>			
22	Ownership	659,020	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 1,573,150</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 50,329</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 50,329</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 678,871	32
33	Private Pay - Net Inpatient Revenue	944,608	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 1,623,479</b>	<b>37</b>



**Brookstone Estates of Fairfield**  
**Adjustments**  
**12/31/2017**

<b>CLIENT_ACT</b>	<b>DESC</b>	<b>DEBIT</b>	<b>TB Acct</b>	<b>IL Acct</b>
5565350000	Charitable Contributions	400.00	9760.00	IS 14.3
5790350000	Bad Debt Expense	27,781.97	9765.00	IS 14.3
5890350000	Miscellaneous Expense	1,637.25	9729.20	IS 14.3
5551330000	Entertainment Expense	368.49	7125.00	IS 7.2
5545340000	Television Cost Expense	9,529.87	7126.00	IS 7.2
5912346000	Special Events - Corp. Directive	3,325.98	9729.20	IS 14.3
		43,043.56		