

		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: 1000010

Facility Name: Brookstone Estates Paris

Address: 146 Brookstone Lane Paris 61944
Number City Zip Code

County: _____

Telephone Number: (217-463-5871 **Fax #** 217-463-5875)

Federal Employer ID Number: _____

Date Current Owners were Certified: 09/01/2009

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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: Bryan Starnes **Telephone Number:** 838-261-7322
Email Address: bstarnes@meridiansenior.com

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) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
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 Brooks Brookstone Midwest Care Paris 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	46	Single Unit Apartment	46	12,558	1
2		Double Unit Apartment			2
3		Other			3
4	46	TOTALS	46	12,558	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	6,825	5,450		12,275	5
6	Double Unit					6
7	Other					7
8	TOTALS	6,825	5,450		12,275	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.74%

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

ACCRUAL MODIFIED CASH* 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. _____

Facility Name: Brool Brookstone Midwest Care Paris LLC

Ending: 09/30/2014

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	59,076	64,679	11,730	135,485		135,485	1
2	Housekeeping, Laundry and Maintenance	46,527	8,096	7,723	62,346		62,346	2
3	Heat and Other Utilities			34,205	34,205		34,205	3
4	Other (specify):			14,224	14,224		14,224	4
5	TOTAL General Services	105,603	72,775	67,882	246,260		246,260	5
B. Health Care and Programs								
6	Health Care/ Personal Care	100,315	1,113	17,506	118,935		118,935	6
7	Activities and Social Services		1,878	10,087	11,965		11,965	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	100,315	2,991	27,594	130,900		130,900	9
C. General Administration								
10	Administrative and Clerical	28,250	2,756	19,311	50,316		50,316	10
11	Marketing Materials, Promotions and Advertising			4,689	4,689		4,689	11
12	Employee Benefits and Payroll Taxes			28,839	28,839		28,839	12
13	Insurance-Property, Liability and Malpractice			19,727	19,727		19,727	13
14	Other (specify):			63,760	63,760		63,760	14
15	TOTAL General Administration	28,250	2,756	136,325	167,331		167,331	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	234,168	78,522	231,801	544,491		544,491	16
Capital Expenses								
D. Ownership								
17	Depreciation			5,304	5,304		5,304	17
18	Interest							18
19	Real Estate Taxes			50,296	50,296		50,296	19
20	Rent -- Facility and Grounds			415,927	415,927		415,927	20
21	Rent -- Equipment			10,884	10,884		10,884	21
22	Other (specify):			-				22
23	TOTAL Ownership			482,411	482,411		482,411	23
24	GRAND TOTAL (Sum of lines 16 and 23)	234,168	78,522	714,212	1,026,902		1,026,902	24

Facility Name: **Brookstone Midwest Care Paris 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	31.04	2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	2	10.34	6
7	Cook Helpers/Assistants	2	8.88	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	2	9.21	10
11	Laundry			11
12	Managers	1	16.32	12
13	Other Administrative	7	9.30	13
14	Clerical	1	13.38	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	16	\$	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	Meridian Senior Living LLC	\$ 51,769	1
2			2
Total		\$ 51,769	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 Midwest Care Paris 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	\$ 5,951	\$ 608	\$ 608		5	\$ 2,027	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 5,951	\$ 608	\$ 608			\$ 2,027	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	Furniture and Other Improvement - 2013	8,113	\$ 1,039	\$ 2,885	22
23	Furniture and Other Improvement - 2014	8,474	3,049	3,049	23
24	TOTALS (lines 21, 22 and 23)	\$ 16,587	\$ 4,088	\$ 5,934	24

Facility Name: Brookstone Midwest Care Paris 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	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building		45	04/01/2011	\$ 702,975	10		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		45		\$ 702,975			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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			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 Midwest Care Paris 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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 46,153	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	<u>271,222</u>		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,047		6
7	Other Prepaid Expenses	(1,427)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 324,995	\$	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	16,587		15
16	Equipment, at Historical Cost	5,951		16
17	Accumulated Depreciation (book methods)	(7,960)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	<u> </u>		20
21	Restricted Funds	176,247		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 190,825	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 515,820	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 221,308	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,260		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	16,017		30
31	Accrued Taxes Payable	(16,311)		31
32	Accrued Interest Payable			32
33	Deferred Compensation	(12,681)		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Deferred lease payment	38,305		35
36	Deferred Lease Payment	7,402		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 267,300	\$	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)	\$ 267,300	\$	45
46	TOTAL EQUITY	\$ 248,520	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 515,820	\$	47

*(See instructions.)

Facility Name: **Brookstone Midwest Care Paris LLC**

01/01/2014

Ending:

09/30/2014

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	\$ 1,224,609	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,224,609	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	85	8
9	Non-Resident Meals	10	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 95	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	90	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 90	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,224,848	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	246,260	19
20	Health Care/ Personal Care	130,900	20
21	General Administration	167,331	21
B. Capital Expense			
22	Ownership	482,411	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)	\$ 1,026,902	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 197,946	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 197,946	31

