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: 1000018

Facility Name: Brookstone Emerald Glen Olny

Address: 1301 North East St (Number) Olney (City) 62450 (Zip Code)

County: Richland

Telephone Number: (618-395-4663 **Fax #**

Federal Employer ID Number:

Date Current Owners were Certified: 09/01/2009

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	

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 # ( )

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

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 of Emerald Glen of Olney 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 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	6,279	5,880		12,159	5
6	Double Unit					6
7	Other					7
8	TOTALS	6,279	5,880		12,159	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.82%

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: 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 of Emerald Glen of Olney **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	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	28,154	57,546	4,534	90,234		90,234	1
2	Housekeeping, Laundry and Maintenance	18,568	11,210	3,857	33,635		33,635	2
3	Heat and Other Utilities			46,653	46,653		46,653	3
4	Other (specify):repait & maintenance			14,446	14,446		14,446	4
5	**TOTAL General Services**	46,722	68,756	69,490	184,968		184,968	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	127,407	2,121	20,573	150,101		150,101	6
7	Activities and Social Services		1,567	3,177	4,744		4,744	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	127,407	3,688	23,750	154,845		154,845	9
	C. General Administration							
10	Administrative and Clerical	44,230	2,510	17,929	64,669		64,669	10
11	Marketing Materials, Promotions and Advertising			12,648	12,648		12,648	11
12	Employee Benefits and Payroll Taxes			16,376	16,376		16,376	12
13	Insurance-Property, Liability and Malpractice			28,023	28,023		28,023	13
14	Other (specify): management fee			43,985	43,985		43,985	14
15	**TOTAL General Administration**	44,230	2,510	118,961	165,701		165,701	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	218,359	74,954	212,201	505,514		505,514	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			9,152	9,152		9,152	17
18	Interest							18
19	Real Estate Taxes			43,001	43,001		43,001	19
20	Rent -- Facility and Grounds			181,139	181,139		181,139	20
21	Rent -- Equipment			2,515	2,515		2,515	21
22	Other (specify):			-				22
23	**TOTAL Ownership**			235,807	235,807		235,807	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	218,359	74,954	448,008	741,321		741,321	24

Facility Name: Brookstone of Emerald Glen of Olney 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	19.10	2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants	2	12.98	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	4	9.95	7
8	Dishwashers			8
9	Maintenance Workers	1	10.93	9
10	Housekeepers	1	9.85	10
11	Laundry			11
12	Managers	1	14.79	12
13	Other Administrative	15	8.50	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	25	$	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	$ 43,985	1
2			2
		Total $ 43,985	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 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 [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: Bro Brookstone of Emerald Glen of Olney 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	$ 12,684	$ 2,604	$ 2,604	$	5	$ 3,452	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 12,684	$ 2,604	$ 2,604	$		$ 3,452	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	18,036	$ $ 3,623	$ 7,263	22
23	Furniture and Other Improvement - 2014	41,144	776	776	23
24	TOTALS (lines 21, 22 and 23)	$ 59,180	$ 4,399	$ 8,039	24

Facility Name: Brookstone of Emerald Glen of Olney Report Period Beginning: 01/01/2014 Ending: 9/30/2014

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? [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		46		04/$	306,150	10	3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		46		$			7

8. Is movable equipment rental included in building rental? [ ] YES [X] 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 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 of Emerald Glen of Olney **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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 139,933	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	236,768		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,246		6
7	Other Prepaid Expenses	(1,321)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 383,626	$	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	48,866		15
16	Equipment, at Historical Cost	22,080		16
17	Accumulated Depreciation (book methods)	(20,643)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	67,544		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 117,847	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 501,473	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 62,880	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(2,979)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,233		30
31	Accrued Taxes Payable	(15,662)		31
32	Accrued Interest Payable			32
33	Deferred Compensation	(16,609)		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Deferred lease payment	16,787		35
36	Deferred Lease Payment	17,286		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 75,936	$	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)**	$ 75,936	$	45
46	**TOTAL EQUITY**	$ 425,537	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 501,473	$	47

***(See instructions.)**

Facility Name: Brookstone of Emerald Glen of Olney **01/01/2014** **Ending:** **09/30/2014**

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	$ 839,300	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 839,300	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	77	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 77	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**	180	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 180	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 839,611	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	184,968	19
20	Health Care/ Personal Care	154,845	20
21	General Administration	165,701	21
	B. Capital Expense		
22	Ownership	235,807	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)**	$ 741,321	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 98,290	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 98,290	31