

		FOR BHF USE			

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Supportive Living Facility
2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2008)

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.</p> <p>Facility Name: <u>Brookstone Estates of Rantoul</u></p> <p>Address: <u>300 Twin Lakes</u> <u>Rantoul</u> <u>61866</u> Number City Zip Code</p> <p>County: <u>Champaign</u></p> <p>Telephone Number: (<u>217</u>) <u>892-5871</u> Fax # <u>217 892-2128</u></p> <p>Federal Employer ID Number: <u>20-1863763</u></p> <p>Date Current Owners were Certified: _____</p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input 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>John Holtz</u> Telephone Number: <u>(541) 747-3373 ext 4100</u> Email Address: <u>jholtz@goodneighbor.com</u></p>	<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 _____		<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>1/1/08</u> to <u>12/31/08</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 border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) (_____) Fax # (_____)</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) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) (_____) Fax # (_____)
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
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	(Firm Name & Address) _____																																				
	(Telephone) (_____) Fax # (_____)																																				

Facility Name: Brookstone Estates of Rantoul

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	87,984	103,880		191,864		191,864	1
2	Housekeeping, Laundry and Maintenance	37,780	923	16,671	55,374		55,374	2
3	Heat and Other Utilities			72,404	72,404		72,404	3
4	Other (specify): Allocated (Shared Maintenance)	19,519			19,519		19,519	4
5	TOTAL General Services	145,283	104,803	89,075	339,161		339,161	5
B. Health Care and Programs								
6	Health Care/ Personal Care	119,624			119,624		119,624	6
7	Activities and Social Services		3,499		3,499		3,499	7
8	Other (specify): Allocated							8
9	TOTAL Health Care and Programs	119,624	3,499		123,123		123,123	9
C. General Administration								
10	Administrative and Clerical	60,380	12,436	25,073	97,889		97,889	10
11	Marketing Materials, Promotions and Advertising			9,775	9,775		9,775	11
12	Employee Benefits and Payroll Taxes	38,945		43,284	82,229		82,229	12
13	Insurance-Property, Liability and Malpractice			15,800	15,800		15,800	13
14	Other (specify): Other income expense prior year			33,290	33,290		33,290	14
15	TOTAL General Administration	99,325	12,436	127,222	238,983		238,983	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	364,232	120,738	216,297	701,267		701,267	16
Capital Expenses								
D. Ownership								
17	Depreciation			15	15		15	17
18	Interest			1,431	1,431		1,431	18
19	Real Estate Taxes			88,346	88,346		88,346	19
20	Rent -- Facility and Grounds			463,906	463,906		463,906	20
21	Rent -- Equipment							21
22	Other (specify): Management Fees			60,894	60,894		60,894	22
23	TOTAL Ownership			614,592	614,592		614,592	23
24	GRAND TOTAL (Sum of lines 16 and 23)	364,232	120,738	830,889	1,315,859		1,315,859	24

Facility Name: Brookstone Estates of Rantoul

Report Period Beginning 1/1/08 Ending: 12/31/08

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			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers	5.1	16.48	5
6	Head Cook			6
7	Cook Helpers/Assistants	4.7	8.99	7
8	Dishwashers			8
9	Maintenance Workers	0.4	10.76	9
10	Housekeepers	1.5	8.61	10
11	Laundry			11
12	Managers	1.2	15.13	12
13	Other Administrative	0.3	20.30	13
14	Clerical	0.3	11.40	14
15	Marketing			15
16	Other- Allocated	0.9	10.76	16
17	Total (lines 1 thru 16)	14.4	\$	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	\$	1
2		2
Total		\$

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 <u>1</u>	City <u>2</u>
_____	_____
_____	_____
_____	_____

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 of Rantoul

Report Period Beginning: 1/1/08

Ending: 12/31/08

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		Leasehold Improvements			328	15	10		(15)	15	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)				\$ 328	\$ 15		\$	(15)	\$ 15	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	\$	\$	\$	\$	7	\$	18
19	Vehicles	19,500	1,950		(1,950)		1,950	19
20	TOTAL (lines 18 and 19)	\$ 19,500	\$ 1,950	\$	(1,950)		\$ 1,950	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 Rantoul

Report Period Beginning: 1/1/08

Ending: 12/31/08

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Wakefield Capital

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			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				\$			7

8. Is movable equipment rental included in building rental? YES 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		3	4	6		7	8	9	
			Related**	YES			NO	Amount of Note				
							Original					
		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.

STATE OF ILLINOIS

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Facility Name: Brookstone Estates of Rantoul

Report Period Beginning: 1/1/08

Ending:

12/31/08

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 443	\$	1
2	Cash-Security Deposits	2,600		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	114,045		3
4	Supply/Food Inventory (priced at 3 wks)	4,945		4
5	Short-Term Investments			5
6	Prepaid Insurance	8,186		6
7	Other Prepaid Expenses	1,898		7
8	Accounts Receivable (1903 owners or related parties)	330		8
9	Other(specify): Intercompany Bal. Sheet True-up (1903)	54,776		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 187,224	\$	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	328		15
16	Equipment, at Historical Cost	19,500		16
17	Accumulated Depreciation (book methods)	(1,965)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds-Escrow Deposits	118,890		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 136,753	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 323,977	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 90,122	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,900		28
29	Short-Term Notes Payable			29
30	Accrued Salaries & Taxes Payable	15,782		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Comp- Accrued Vacation & PTO	9,705		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accounts Payable- Interco			35
36	Property Taxes Payable	88,037		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 234,546	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	14,527		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)	\$ 14,527	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 249,073	\$	45
46	TOTAL EQUITY	\$ 168,292	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 417,365	\$	47

*(See instructions.)

Facility Name: Brookstone Estates of Rantoul

Report Period Beginning: 1/1/08

Ending:

12/31/08

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	\$ 1,212,813	1
2	Discounts and Allowances	(3,797)	2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 1,209,016	3
	B. Other Operating Revenue		
4	Special Services- (Level of Care & Move in Fees)	7,900	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
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$ 7,900	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$	14
	D. Other Revenue (specify):		
15	Food Stamp Revenue	3,558	15
16	Miscellaneous	1,093	16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$ 4,651	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 1,221,567	18

		2	
	Expenses	Amount	
	A. Operating Expenses		
19	General Services	339,161	19
20	Health Care/ Personal Care	123,123	20
21	General Administration	238,983	21
	B. Capital Expense		
22	Ownership	614,592	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify): Unallocated	(904)	25
26			26
27			27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 1,314,955	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ (93,388)	29
	Income Taxes		
30		\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ (93,388)	31