FOR BHF USE

LL2

Supportive Living Facility

2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2009)

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 Name: Brookstone Estates of Harrisburg

Address: 165 Ron Morse Drive (Number) Harrisburg (City) 62946 (Zip Code)

County: Saline

Telephone Number: (618) 253-5870 **Fax #** 618 253-5871

Federal Employer ID Number: 20-1902398 & 26-3906897 eff 9/1/09

Date Current Owners were Certified:

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 1/1/09 to 12/31/09 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: Alicia Mullerleile **Telephone Number:** (541) 747-3373 ext 4113

Email Address: amullerleile@goodneighbor.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 Brookstone Estates of Harrisburg Report Period Beginning: 1/1/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units / /

	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	16,790	1
2		Double Unit Apartment			2
3		Other			3
4	46	TOTALS	46	16,790	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	6,598	10,179		16,777	5
6	Double Unit					6
7	Other					7
8	TOTALS	6,598	10,179		16,777	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.92%

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	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: Fiscal Year:
* 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 of Harrisburg **Report Period Beginning: 1/1/09 Ending: 12/31/09**

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	68,927	81,917		150,844		150,844	1
2	Housekeeping, Laundry and Maintenance	17,520	11,868	28,136	57,524		57,524	2
3	Heat and Other Utilities			70,748	70,748		70,748	3
4	Other (specify):							4
5	**TOTAL General Services**	86,447	93,785	98,884	279,116		279,116	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	132,369			132,369		132,369	6
7	Activities and Social Services		2,695		2,695		2,695	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	132,369	2,695		135,064		135,064	9
	C. General Administration							
10	Administrative and Clerical	72,264	7,847	17,506	97,617		97,617	10
11	Marketing Materials, Promotions and Advertising			12,217	12,217		12,217	11
12	Employee Benefits and Payroll Taxes	27,054		47,791	74,845		74,845	12
13	Insurance-Property, Liability and Malpractice			12,243	12,243		12,243	13
14	Other (specify): Prior year Adjustments			1,859	1,859		1,859	14
15	**TOTAL General Administration**	99,318	7,847	91,616	198,781		198,781	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	318,134	104,327	190,500	612,961		612,961	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			104	104		104	17
18	Interest			148	148		148	18
19	Real Estate Taxes			84,697	84,697		84,697	19
20	Rent -- Facility and Grounds			545,633	545,633		545,633	20
21	Rent -- Equipment			501	501		501	21
22	Other (specify): Management fees			69,505	69,505		69,505	22
23	**TOTAL Ownership**			700,588	700,588		700,588	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	318,134	104,327	891,088	1,313,549		1,313,549	24

Facility Name: Brookstone Estates of Harrisburg Report Period Beginning: 1/1/09 Ending: 12/31/09

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.4	$ 22.23	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers	6.2	8.72	5
6	Head Cook			6
7	Cook Helpers/Assistants	3.6	9.26	7
8	Dishwashers			8
9	Maintenance Workers	0.1	11.09	9
10	Housekeepers	0.8	8.97	10
11	Laundry			11
12	Managers	1.0	21.88	12
13	Other Administrative			13
14	Clerical	1.0	12.75	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	13.1	$	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	Good Neighbor Care LLC (listed on pg 3, line 22)	$ 69,505	1
2			2
	Total	$ 69,505	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: Brookstone Estates of Harrisburg Report Period Beginning: 1/1/09 Ending: 12/31/09

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			2009	2,452	51	10		(51)	51	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)				$ 2,452	$ 51		$	$ (51)	$ 51	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	$ 1,984	$ 53	$	(53)	7	$ 53	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 1,984	$ 53	$	(53)		$ 53	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 Harrisburg Report Period Beginning: 1/1/09 Ending: 12/31/09

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Midwest Care Holdco TRS, 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			/ /	$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				$			7

8. Is movable equipment rental included in building rental? [ ] YES [X] 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 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 Estates of Harrisburg **Report Period Beginning:** 1/1/09 **Ending:** 12/31/09

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Security Deposits	2,400		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	130,065		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,737		6
7	Other Prepaid Expenses	69		7
8	Accounts Receivable (1903 owners or related parties)			8
9	Other(specify): Intercompany Bal. Sheet True-up (1902)			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 135,271	$	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	2,452		15
16	Equipment, at Historical Cost	1,121		16
17	Accumulated Depreciation (book methods)	(104)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	3,576		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,045	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 142,316	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 40,809	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,684		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,657		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation	12,130		33
34	Income Taxes	30,090		34
	Other Current Liabilities(specify):			
35	Accounts Payable- Interco	(32,354)		35
36	Property Taxes Payable	74,733		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 179,749	$	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)**	$ 179,749	$	45
46	**TOTAL EQUITY**	$ (37,433)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 142,316	$	47

***(See instructions.)**

Facility Name: Brookstone Estates of Harrisburg **Report Period Beginning: 1/1/09 Ending: 12/31/09**

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	$ 1,321,042	1
2	Discounts and Allowances	(16,643)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,304,399	3
	B. Other Operating Revenue		
4	Special Services- (Level of Care & Move in Fees)	56,078	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)**	$ 56,078	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	**Food Stamp Revenue**	25,302	15
16	**Miscellaneous**	2,521	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 27,823	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,388,300	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	279,116	19
20	Health Care/ Personal Care	135,064	20
21	General Administration	198,781	21
	B. Capital Expense		
22	Ownership		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)**	$ 612,961	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 775,339	29
30	**Income Taxes**	$ 30,090	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 745,249	31