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 Robinson

Address: 1101 North Monroe Street (Number) Robinson (City) 62454 (Zip Code)

County: Crawford

Telephone Number: (618) 544-4663 **Fax #**

Federal Employer ID Number: 20-3572552 & 26-3908839 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	

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

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 # ( )

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 Robinson 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	42	Single Unit Apartment	42	15,330	1
2		Double Unit Apartment			2
3		Other			3
4	42	TOTALS	42	15,330	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	6,828	8,820		15,648	5
6	Double Unit					6
7	Other					7
8	TOTALS	6,828	8,820		15,648	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 102.07%

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 Robinson **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	42,918	65,507		108,425		108,425	1
2	Housekeeping, Laundry and Maintenance	12,313	10,519	16,263	39,095		39,095	2
3	Heat and Other Utilities			53,970	53,970		53,970	3
4	Other (specify):							4
5	**TOTAL General Services**	55,231	76,026	70,233	201,490		201,490	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	192,294	478		192,772		192,772	6
7	Activities and Social Services		2,088		2,088		2,088	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	192,294	2,566		194,860		194,860	9
	C. General Administration							
10	Administrative and Clerical	67,803	6,565	13,658	88,026		88,026	10
11	Marketing Materials, Promotions and Advertising			6,819	6,819		6,819	11
12	Employee Benefits and Payroll Taxes	24,210		61,245	85,455		85,455	12
13	Insurance-Property, Liability and Malpractice			12,695	12,695		12,695	13
14	Other (specify): Prior year adjustments			2,796	2,796		2,796	14
15	**TOTAL General Administration**	92,013	6,565	97,213	195,791		195,791	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	339,538	85,157	167,446	592,141		592,141	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			4,019	4,019		4,019	17
18	Interest			1,103	1,103		1,103	18
19	Real Estate Taxes			16,308	16,308		16,308	19
20	Rent -- Facility and Grounds			426,586	426,586		426,586	20
21	Rent -- Equipment			1,015	1,015		1,015	21
22	Other (specify): Management fees			62,571	62,571		62,571	22
23	**TOTAL Ownership**			511,602	511,602		511,602	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	339,538	85,157	679,048	1,103,743		1,103,743	24

Facility Name: Brookstone Estates of Robinson **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	0.5	$ 22.74	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers	8.5	9.43	5
6	Head Cook			6
7	Cook Helpers/Assistants	2.0	10.24	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	0.6	9.07	10
11	Laundry			11
12	Managers	1.0	19.80	12
13	Other Administrative			13
14	Clerical	1.0	12.72	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	13.6	$	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)	$ 62,571	1
2			2
	Total	$ 62,571	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 Robinson 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	2690		146	10		(146)	146	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)				$	$ 146		$	$ (146)	$ 146	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	$ 3,391	$ 127	$	(127)	7	$ 127	18
19	Vehicles	14,175	3,747		(3,747)		3,747	19
20	TOTAL (lines 18 and 19)	$ 17,566	$ 3,874	$	(3,874)		$ 3,874	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 Robinson 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 Robinson **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	$ 500	$	1
2	Security Deposits	14,014		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	141,488		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,644		6
7	Other Prepaid Expenses	1,046		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)**	$ 159,692	$	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	2,690		15
16	Equipment, at Historical Cost	16,703		16
17	Accumulated Depreciation (book methods)	(4,019)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	38,386		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 53,760	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 213,452	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 35,425	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,899		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,166		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation	13,825		33
34	Income Taxes	58,204		34
	Other Current Liabilities(specify):			
35	Accounts Payable- Interco	(15,846)		35
36	Property Taxes Payable	16,308		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 138,981	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	9,420		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)**	$ 9,420	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 148,401	$	45
46	**TOTAL EQUITY**	$ 65,051	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 213,452	$	47

***(See instructions.)**

Facility Name: Brookstone Estates of Robinson **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	$ 1,175,298	1
2	Discounts and Allowances	(4,239)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,171,059	3
	B. Other Operating Revenue		
4	Special Services- (Level of Care & Move in Fees)	58,398	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)**	$ 58,398	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**	22,945	15
16	**Miscellaneous**	1,828	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 24,773	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,254,230	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	201,490	19
20	Health Care/ Personal Care	194,860	20
21	General Administration	195,791	21
	B. Capital Expense		
22	Ownership	511,602	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)**	$ 1,103,743	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 150,487	29
30	**Income Taxes**	$ 58,204	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 92,283	31