

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2017  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2017)**

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><b>I. Facility ID Number:</b> <u>1000070</u></p> <p><b>Facility Name:</b> <u>Brookstone Estates Harrisbrg</u></p> <hr/> <p><b>Address:</b> <u>165 Ron Morse Drive</u> <u>Harrisburg</u> <u>62946</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>Saline</u></p> <p><b>Telephone Number:</b> ( <u>618</u> ) <u>253-5870</u> Fax # ( )</p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>06/01/15</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" 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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>Anna Kobrzak</u> <b>Telephone Number:</b> ( <u>312</u> ) <u>673-4360</u></p> <p><b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/17</u> to <u>12/31/17</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 style="width:100%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Steve Hippel</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> <td></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Chris Joos Partner</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Plante &amp; Moran, PLLC 250 South High Street, Suite 100</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(614) 222-9040</u> Fax <u>(614) 221-3535</u></td> <td></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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>Steve Hippel</u>			(Title) <u>Chief Financial Officer</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____		(Print Name and Title) <u>Chris Joos Partner</u>			(Firm Name & Address) <u>Plante &amp; Moran, PLLC 250 South High Street, Suite 100</u>			(Telephone) <u>(614) 222-9040</u> Fax <u>(614) 221-3535</u>	
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Facility Name: Brookstone Estates Harrisbrg

Report Period Beginning:

1/1/17

Ending:

12/31/17

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	45,870	82,387	3,427	131,684		131,684	1
2	Housekeeping, Laundry and Maintenance	29,402	42,999	2,879	75,280		75,280	2
3	Heat and Other Utilities			55,059	55,059		55,059	3
4	Other (specify):			1,501	1,501		1,501	4
5	<b>TOTAL General Services</b>	75,272	125,386	62,866	263,524		263,524	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	242,788	440	5,415	248,643		248,643	6
7	Activities and Social Services	10,554	10,979	202	21,735	(8,742)	12,993	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	253,342	11,419	5,617	270,378	(8,742)	261,636	9
<b>C. General Administration</b>								
10	Administrative and Clerical	83,315	698	130,154	214,167		214,167	10
11	Marketing Materials, Promotions and Advertising		366	24,878	25,244		25,244	11
12	Employee Benefits and Payroll Taxes			69,146	69,146		69,146	12
13	Insurance-Property, Liability and Malpractice			27,728	27,728		27,728	13
14	Other (specify):			56,922	56,922	(56,922)		14
15	<b>TOTAL General Administration</b>	83,315	1,064	308,828	393,207	(56,922)	336,285	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	411,929	137,869	377,311	927,109	(65,664)	861,445	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			18,648	18,648		18,648	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			688,712	688,712		688,712	20
21	Rent -- Equipment			10,625	10,625		10,625	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			717,985	717,985		717,985	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	411,929	137,869	1,095,296	1,645,094	(65,664)	1,579,430	24

Facility Name: Brookstone Estates Harrisbrg

Report Period Beginning 1/1/17

Ending: 12/31/17

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.00	\$ 21.97	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	8.00	10.52	3
4	Activity Director & Assistants	1.00	9.50	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	3.00	9.40	7
8	Dishwashers			8
9	Maintenance Workers	1.00	11.50	9
10	Housekeepers	1.00	10.00	10
11	Laundry			11
12	Managers	2.00	16.00	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>17</b>	<b>\$</b>	<b>17</b>

**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
				<b>Total</b>	<b>6</b>
				\$	

**VI. (B) Management fees paid to unrelated parties**

		Amount of Fee	
1	Senior Lifestyle Corporation	\$ 95,867	1
2			2
		<b>Total</b>	<b>3</b>
		\$	95,867

**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 Estates Harrisbrg

Report Period Beginning:

1/1/17

Ending:

12/31/17

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
	<b>Improvement Type</b>										
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	<b>TOTAL (lines 1 thru 16)</b>				\$	\$		\$	\$	\$	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	\$ 106,416	\$ 18,648	\$ 18,648		5-7	\$ 38,073	18
19	Vehicles							19
20	<b>TOTAL (lines 18 and 19)</b>	\$ 106,416	\$ 18,648	\$ 18,648			\$ 38,073	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	<b>TOTALS (lines 21, 22 and 23)</b>	\$	\$	\$	24

Facility Name: Brookstone Estates Harrisbrg

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**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: WC-Harrisburg 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	2005	46	06/01/15	\$ 688,712	5		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	<b>TOTAL</b>		46		\$ 688,712			7

8. Is movable equipment rental included in building rental?  YES  NO

9. Rental amount for movable equipment \$ 10,625

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				
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1						/ /	\$	\$	/ /			1
2						/ /			/ /			2
3						/ /			/ /			3
<b>Working Capital</b>												
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7	<b>TOTAL Facility Related</b>						\$	\$			\$	7
<b>B. Non-Facility Related</b>												
8						/ /			/ /			8
9						/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>						\$	\$			\$	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 Harrisbrg

Report Period Beginning: 1/1/17

Ending:

12/31/17

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (1,378)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	265,946 (65,857)		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,054		6
7	Other Prepaid Expenses	4,606		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 227,371	\$	10
	<b>B. Long-Term Assets</b>			
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			15
16	Equipment, at Historical Cost	106,416		16
17	Accumulated Depreciation (book methods)	(38,073)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 68,343	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 295,714	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 42,926	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,989		30
31	Accrued Taxes Payable	2,873		31
32	Accrued Interest Payable	16,583		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	Accrued Other	293,284		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 386,655	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42	Intercompany	360,837		42
43	Deferred Revenues	12,527		43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 373,364	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 760,019	\$	45
46	<b>TOTAL EQUITY</b>	\$ (464,305)	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 295,714	\$	47

\*(See instructions.)

Facility Name: Brookstone Estates Harrisbrg

Report Period Beginning: 1/1/17

Ending:

12/31/17

**XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)**

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 1,516,482	1
2	Discounts and Allowances	(237)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 1,516,245</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
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		8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	9	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 9</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 1,516,254</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	263,524	19
20	Health Care/ Personal Care	270,378	20
21	General Administration	393,207	21
<b>B. Capital Expense</b>			
22	Ownership	717,985	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 1,645,094</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (128,840)</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ (128,840)</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 644,883	32
33	Private Pay - Net Inpatient Revenue	871,362	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 1,516,245</b>	<b>37</b>

**Brookstone Estates of Harrisburg**  
**Adjustments**  
**12/31/2017**

<b>CLIENT_ACT</b>	<b>DESC</b>	<b>DEBIT</b>	<b>TB Acct</b>	<b>IL Acct</b>
5565350000	Charitable Contributions	450.00	9760.00	IS 14.3
5790350000	Bad Debt Expense	50331.95	9765.00	IS 14.3
5890350000	Miscellaneous Expense	3096.96	9729.20	IS 14.3
5545340000	Television Cost Expense	8742.24	7126.00	IS 7.2
5771350000	Penalties	11.79	9730.00	IS 14.3
5912346000	Special Events - Corp. Directive	3,031.14	9729.20	IS 14.3
		65,664.08		