

		FOR BHF USE			

LL2

Supportive Living Facility

**2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)**

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. Facility ID Number: <u>1000016</u></p> <p>Facility Name: <u>Brookstone Ests of Robinson</u></p> <hr/> <p>Address: <u>1101 North Monroe St</u> <u>Robinson</u> <u>62454</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Crawford</u></p> <p>Telephone Number: (<u>618</u>) <u>544-4663</u> Fax # ()</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>06/01/15</u></p> <p>Type of Ownership:</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>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:</p> <p>Name: <u>Anna Kobrzak</u> Telephone Number: (<u>312</u>) <u>673-4360</u></p> <p>Email Address: _____</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	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>1/1/18</u> to <u>12/31/18</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%;">Officer or Administrator of Provider</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>Paid Preparer</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 & Address) <u>Plante & Moran, PLLC</u> <u>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>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Steve Hippel</u>			(Title) <u>Chief Financial Officer</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Chris Joos Partner</u>			(Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>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 Ests of Robinson

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	43,197	62,676	1,837	107,710		107,710	1
2	Housekeeping, Laundry and Maintenance	30,847	53,183		84,030		84,030	2
3	Heat and Other Utilities			58,163	58,163		58,163	3
4	Other (specify):			2,555	2,555		2,555	4
5	TOTAL General Services	74,044	115,859	62,555	252,458		252,458	5
B. Health Care and Programs								
6	Health Care/ Personal Care	256,203	573	1,745	258,521		258,521	6
7	Activities and Social Services	22,471	2,779	168	25,418	(410)	25,008	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	278,640	3,352	1,913	283,939	(410)	283,529	9
C. General Administration								
10	Administrative and Clerical	74,114	7,357	135,825	217,296	75	217,371	10
11	Marketing Materials, Promotions and Advertising		2,109	22,697	24,806		24,806	11
12	Employee Benefits and Payroll Taxes			67,243	67,243		67,243	12
13	Insurance-Property, Liability and Malpractice			21,318	21,318		21,318	13
14	Other (specify):			106,506	106,506	(106,506)		14
15	TOTAL General Administration	74,114	9,466	353,589	437,169	(106,431)	330,738	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	426,798	128,677	418,057	973,566	(106,841)	866,725	16
Capital Expenses								
D. Ownership								
17	Depreciation			19,427	19,427		19,427	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			449,488	449,488		449,488	20
21	Rent -- Equipment			2,766	2,766		2,766	21
22	Other (specify):							22
23	TOTAL Ownership			471,681	471,681		471,681	23
24	GRAND TOTAL (Sum of lines 16 and 23)	426,798	128,677	889,738	1,445,247	(106,841)	1,338,406	24

Facility Name: Brookstone Ests of Robinson

Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.06	\$ 22.29	1
2	Licensed Practical Nurses	0.87	27.41	2
3	Certified Nurse Assistants	8.66	11.32	3
4	Activity Director & Assistants	0.91	11.85	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	0.96	11.48	7
8	Dishwashers			8
9	Maintenance Workers	0.42	15.53	9
10	Housekeepers	0.82	10.13	10
11	Laundry			11
12	Managers	0.81	12.03	12
13	Other Administrative	0.31	30.61	13
14	Clerical	0.97	28.60	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	14.79	\$	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	Senior Lifestyle Corporation	\$ 83,841	1
2			2
		Total	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

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 Ests of Robinson

Report Period Beginning:

1/1/18

Ending:

12/31/18

VIII. OWNERSHIP COSTS

A. Purchase price of land N/A

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	\$ 115,897	\$ 19,427	\$ 19,427		5-7	\$ 44,845	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 115,897	\$ 19,427	\$ 19,427			\$ 44,845	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 Ests of Robinson

Report Period Beginning: 1/1/18

Ending: 12/31/18

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: WC-Robinson 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 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	1999	42	06/01/15	\$ 449,488			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		42		\$ 449,488			7

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

9. Rental amount for movable equipment \$ 2,766

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**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	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 Ests of Robinson

Report Period Beginning: 1/1/18

Ending:

12/31/18

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (3,328)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	330,592 (93,151)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,141		6
7	Other Prepaid Expenses	3,106		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 250,360	\$	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			15
16	Equipment, at Historical Cost	115,896		16
17	Accumulated Depreciation (book methods)	(44,845)		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):	75		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 71,126	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 321,486	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 13,666	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,098		30
31	Accrued Taxes Payable	639		31
32	Accrued Interest Payable	9,631		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Other	248,718		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 305,752	\$	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	Intercompany	589,643		42
43	Deferred Revenues	27,352		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 616,995	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 922,747	\$	45
46	TOTAL EQUITY	\$ (601,261)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 321,486	\$	47

*(See instructions.)

Facility Name: Brookstone Ests of Robinson

Report Period Beginning: 1/1/18

Ending:

12/31/18

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

		1	
I. Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,421,415	1
2	Discounts and Allowances	(4,309)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,417,106	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		8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	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			15
16	CABLE REVENUE		16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,417,106	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	252,458	19
20	Health Care/ Personal Care	283,939	20
21	General Administration	437,169	21
B. Capital Expense			
22	Ownership	471,681	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)	\$ 1,445,247	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (28,141)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (28,141)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 664,135	32
33	Private Pay - Net Inpatient Revenue	752,971	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,417,106	37

Brookstone Estates Robinson
Adjustments
12/31/2018

CLIENT_ACT	DESC	DEBIT	TB Acct	IL Acct
5565350000	Charitable Contributions	400.00	9760.00	IS 14.3
5790350000	Bad Debt Expense	61,194.00	9765.00	IS 14.3
5890350000	Miscellaneous Expense	2,227.13	9729.20	IS 14.3
5912346000	Special Events - Corp. Directive	42,684.47	9729.20	IS 14.3
5551330000	Entertainment Expense	410.00	7125.00	IS 7.2
5551350000	Entertainment Expense Administratic	(75.00)	7615.00	IS 10.2
		106,840.60		