

		FOR BHF USE			

LL2

Supportive Living Facility

**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2011)**

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>1000018</u></p> <p>Facility Name: <u>Brookstone of Emerald Glen of Olney</u></p> <p>Address: <u>1301 North East St.</u> <u>Olney</u> <u>62450</u> <small>Number City Zip Code</small></p> <p>County: <u>Richland</u></p> <p>Telephone Number: (<u>618</u>) <u>395-4663</u> Fax # (<u> </u>)</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>09/01/2009</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <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>Steve Pavlue</u> Telephone Number: (<u>240</u>) <u>841-2921</u> Email Address: _____</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>01/01/2011</u> to <u>12/31/2011</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%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____</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) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name: Brookstone of Emerald Glen of Olney

Report Period Beginning:

01/01/2011

Ending: 12/31/2011

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	7,533	73,129	458	81,120		81,120	1
2	Housekeeping, Laundry and Maintenance	11,383	3,371	1,162	15,915		15,915	2
3	Heat and Other Utilities			35,317	35,317		35,317	3
4	Other (specify):			16,069	16,069		16,069	4
5	TOTAL General Services	18,916	76,500	53,006	148,422		148,422	5
B. Health Care and Programs								
6	Health Care/ Personal Care	40,938	804		41,742		41,742	6
7	Activities and Social Services		5,510		5,510		5,510	7
8	Other (specify):			4,361	4,361		4,361	8
9	TOTAL Health Care and Programs	40,938	6,314	4,361	51,613		51,613	9
C. General Administration								
10	Administrative and Clerical	228,988	5,104	84,170	318,262		318,262	10
11	Marketing Materials, Promotions and Advertising			11,829	11,829		11,829	11
12	Employee Benefits and Payroll Taxes			58,654	58,654		58,654	12
13	Insurance-Property, Liability and Malpractice			11,521	11,521		11,521	13
14	Other (specify):							14
15	TOTAL General Administration	228,988	5,104	166,174	400,266		400,266	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	288,842	87,918	223,542	600,301		600,301	16
Capital Expenses								
D. Ownership								
17	Depreciation			1,417	1,417		1,417	17
18	Interest			(213)	(213)		(213)	18
19	Real Estate Taxes			56,535	56,535		56,535	19
20	Rent -- Facility and Grounds			277,893	277,893		277,893	20
21	Rent -- Equipment			1,456	1,456		1,456	21
22	Other (specify):							22
23	TOTAL Ownership			337,088	337,088		337,088	23
24	GRAND TOTAL (Sum of lines 16 and 23)	288,842	87,918	560,630	937,389		937,389	24

Facility Name: Brookstone of Emerald Glen of Olney

Report Period Beginning 01/01/2011

Ending:

12/31/2011

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 18.03	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers	9	10.05	5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers	3	10.54	9
10	Housekeepers	1	9.19	10
11	Laundry			11
12	Managers	3	10.41	12
13	Other Administrative			13
14	Clerical	1	8.41	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	19	\$	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	Meridian Senior Living, LLC	\$ 54,809	1
2			2
Total		\$ 54,809	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 of Emerald Glen of Olney

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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											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	\$	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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 of Emerald Glen of Olney

Report Period Beginning: 01/01/2011

Ending: 2/31/2011

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? 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	Purpose of Loan				
							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 of Emerald Glen of Olney

Report Period Beginning: 01/01/2011

Ending:

12/31/2011

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (25,526)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	171,930		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10		6
7	Other Prepaid Expenses	(4,549)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(35,189)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 106,676	\$	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	13,350		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(172)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,113)		20
21	Restricted Funds	61,635		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	845		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 74,545	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 181,221	\$	25

*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 46,613	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,439		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 109,052	\$	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)	\$ 109,052	\$	45
46	TOTAL EQUITY	\$ 72,169	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 181,221	\$	47

Facility Name: Brookstone of Emerald Glen of Olney

Report Period Beginning: 01/01/2011

Ending:

12/31/2011

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	\$ 1,055,842	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 1,055,842	3
B. Other Operating Revenue			
4	Special Services	700	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)	\$ 700	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			15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,056,542	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	148,422	19
20	Health Care/ Personal Care	51,613	20
21	General Administration	400,266	21
B. Capital Expense			
22	Ownership	337,088	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 937,389	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 119,153	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 119,153	31