

		FOR BHF USE			

LL2

Supportive Living Facility

**2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2006)**

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.</p> <p>Facility Name: <u>Brookstone Estates-Fairfield</u></p> <p>Address: <u>315 North Market</u> <u>Fairfield</u> <u>62837</u> <small>Number City Zip Code</small></p> <p>County: <u>Wayne</u></p> <p>Telephone Number: (<u>217</u>) <u>3425885</u> Fax # <u>217</u>)<u>342-5851</u></p> <p>Federal Employer ID Number: <u>20-1863663</u></p> <p>Date Current Owners were Certified: <u>11/23/04</u></p> <p>Type of Ownership:</p> <table border="0"> <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>Amy Eubank</u> Telephone Number: (<u>217</u>) <u>342-5885</u></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>01-01-2006</u> to <u>12-31-2006</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 border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td><u>3/26/2007</u></td> </tr> <tr> <td>(Type or Print Name) <u>Amy Eubank</u></td> <td>(Date)</td> </tr> <tr> <td></td> <td>(Title) <u>Illinois Director of Operations</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date)</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) (<u> </u>) _____ Fax # (<u> </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) _____	<u>3/26/2007</u>	(Type or Print Name) <u>Amy Eubank</u>	(Date)		(Title) <u>Illinois Director of Operations</u>		Paid Preparer	(Signed) _____	(Date)	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____	
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Facility Name Brookstone Estates-Fairfield

Report Period Beginning: 01-01-2006 Ending: 12-31-2006

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	39	Single Unit Apartment	39	14,235	1
2	7	Double Unit Apartment	7	2,555	2
3		Other			3
4	46	TOTALS	46	16,790	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	6,573	7,448		14,021	5
6	Double Unit	120	2,129		2,249	6
7	Other					7
8	TOTALS	6,693	9,577		16,270	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.90%

D. Indicate the number of paid bed-hold days the SLF had during this year 141 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

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

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*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: Dec Fiscal Year: Dec

* 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-Fairfield

Report Period Beginning:

01-01-2006

Ending: 12-31-2006

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	65,351	69,696		135,047		135,047	1
2	Housekeeping, Laundry and Maintenance	12,486	4,054	10,826	27,366		27,366	2
3	Heat and Other Utilities			59,314	59,314		59,314	3
4	Other (specify): Miscellaneous			16,139	16,139		16,139	4
5	TOTAL General Services	77,837	73,750	86,279	237,866		237,866	5
B. Health Care and Programs								
6	Health Care/ Personal Care	82,040	115	6,397	88,552		88,552	6
7	Activities and Social Services		2,023		2,023		2,023	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	82,040	2,138	6,397	90,575		90,575	9
C. General Administration								
10	Administrative and Clerical	54,822	3,163	102,875	160,860		160,860	10
11	Marketing Materials, Promotions and Advertising			1,674	1,674		1,674	11
12	Employee Benefits and Payroll Taxes			44,555	44,555		44,555	12
13	Insurance-Property, Liability and Malpractice			38,921	38,921		38,921	13
14	Other (specify):							14
15	TOTAL General Administration	54,822	3,163	188,025	246,010		246,010	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	214,699	79,051	280,701	574,451		574,451	16
Capital Expenses								
D. Ownership								
17	Depreciation			209,923	209,923		209,923	17
18	Interest			321,480	321,480		321,480	18
19	Real Estate Taxes			107	107		107	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			531,510	531,510		531,510	23
24	GRAND TOTAL (Sum of lines 16 and 23)	214,699	79,051	812,211	1,105,961		1,105,961	24

Facility Name: Brookstone Estates-Fairfield

Report Period Beginning: 01-01-2006 Ending: 12-31-2006

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$ 20.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	3	7.63	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	10.00	6
7	Cook Helpers/Assistants	2	7.63	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	7.35	10
11	Laundry			11
12	Managers	2	10.71	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	9	\$	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	Wilkinson Corporation Managing Member	30%	5	\$ 22860	1
2					2
3					3
4					4
5					5
Total				\$ 22860	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	Oakshire SeniorLiving	\$ 57,153 1
2		
Total		\$ 57,153 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	City
1 Brookstone Estates Mattoon North	2 Mattoon

OTHER RELATED BUSINESS ENTITIES

Name	City	Type of Business
3 Wilkinson Corporation LLC	4 Yakima WA	5 Investment

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: Wilkinson Corporation LLC If yes, what is the value of those services? \$ 22,860

(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-Fairfield

Report Period Beginning: 01-01-2006

Ending: 12-31-2006

VIII. OWNERSHIP COSTS

A. Purchase price of land 70,000 Year land was acquired 2004

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	46		2004	2001	\$ 2,937,288	\$ 110,847	28	\$ 110,847	\$	\$ 226,145	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)				\$ 2,937,288	\$ 110,847		\$ 110,847	\$	\$ 226,145	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	Land Improvement	\$ 857,576	\$ 57,172	\$ 119,108	21
22	Furniture and Fixtures	155,444	35,626	101,061	22
23	Goodwill and Loan Fees	427,552	6,278	12,869	23
24	TOTALS (lines 21, 22 and 23)	\$ 1,440,572	\$ 99,076	\$ 233,038	24

Facility Name: Brookstone Estates-Fairfield

Report Period Beginning: 01-01-2006

Ending: 2-31-2006

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/a

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	2	3	4	6	7	8	9		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related Long-Term									
1	GEMSA Loan Service		X	Mortgage	12/13/07	\$ 4,860,037	\$ 4,730,577	/ /	6.0000	\$ 288,251
2	GEMSA Loan Service		X	Note	/ /	311,220	304,715	/ /		33,229
3	Fund I	X		Note	/ /		3,803	/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 5,171,257	\$ 5,039,095			\$ 321,480
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 5,171,257	\$ 5,039,095			\$ 321,480

* 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-Fairfield

Report Period Beginning: 01-01-2006

Ending:

12-31-2006

12-31-2006

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-2006

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 14,009	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	128,909		3
4	Supply Inventory (priced at)	1,826		4
5	Short-Term Investments			5
6	Prepaid Insurance	6,030		6
7	Other Prepaid Expenses	42,191		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Business Value	427,553		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 620,518	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	70,000		13
14	Buildings, at Historical Cost	2,937,288		14
15	Leasehold Improvements, at Historical Cost	857,576		15
16	Equipment, at Historical Cost	155,444		16
17	Accumulated Depreciation (book methods)	(446,314)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(12,868)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Monies Loaned to Funds	1,149,543		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,710,669	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,331,187	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 42,754	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,000		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,862		30
31	Accrued Taxes Payable	(2,434)		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Insurance	1,626		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 94,808	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	5,039,095		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)	\$ 5,039,095	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,133,903	\$	45
46	TOTAL EQUITY	\$ 197,284	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,331,187	\$	47

*(See instructions.)

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	\$ 1,143,057	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,143,057	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			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,143,057	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	237,866	19
20	Health Care/ Personal Care	90,575	20
21	General Administration	246,010	21
B. Capital Expense			
22	Ownership	531,510	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)	\$ 1,105,961	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 37,096	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 37,096	31