

		FOR BHF USE			

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**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><b>I.</b></p> <p>Facility Name: <u>Brookstone of Emerald Glen of Olney</u></p> <p>Address: <u>1301 North East</u> <u>Olney Illinois</u> <u>62450</u>  <small>Number City Zip Code</small></p> <p>County: <u>Richland</u></p> <p>Telephone Number: ( <u>217</u> ) <u>342-5885</u> Fax # ( <u>217</u> ) <u>342-5851</u></p> <p>Federal Employer ID Number: <u>20-3572488</u></p> <p>Date Current Owners were Certified: _____</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>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><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>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 style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Amy Eubank</u> (Title) <u>Illinois Director of Operations</u></td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; 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) <u>Amy Eubank</u> (Title) <u>Illinois Director of Operations</u>	Paid Preparer	(Signed) _____ (Date) _____ (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:

01-01-2006

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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	27,953	61,623		89,576		89,576	1
2	Housekeeping, Laundry and Maintenance	14,679	10,856	15,056	40,591		40,591	2
3	Heat and Other Utilities			48,220	48,220		48,220	3
4	Other (specify): Miscellaneous			14,915	14,915		14,915	4
5	<b>TOTAL General Services</b>	42,632	72,479	78,191	193,302		193,302	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	109,120	909	8,995	119,024		119,024	6
7	Activities and Social Services		1,725		1,725		1,725	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	109,120	2,634	8,995	120,749		120,749	9
<b>C. General Administration</b>								
10	Administrative and Clerical	52,124	4,939	66,812	123,875		123,875	10
11	Marketing Materials, Promotions and Advertising			6,931	6,931		6,931	11
12	Employee Benefits and Payroll Taxes			43,823	43,823		43,823	12
13	Insurance-Property, Liability and Malpractice			28,092	28,092		28,092	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	52,124	4,939	145,658	202,721		202,721	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	203,876	80,052	232,844	516,772		516,772	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			81,390	81,390		81,390	17
18	Interest			248,612	248,612		248,612	18
19	Real Estate Taxes			29,062	29,062		29,062	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			359,064	359,064		359,064	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	203,876	80,052	591,908	875,836		875,836	24

Facility Name: Brookstone of Emerald Glen of Olney

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	5	7.60	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	10.00	6
7	Cook Helpers/Assistants	1	7.53	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	7.35	10
11	Laundry			11
12	Managers	2	12.36	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>10</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	Wilkinson Corporation Managing	30%	5	\$ 14847	1
2					2
3					3
4					4
5					5
<b>Total</b>				<b>\$ 14847</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	Oakshire Senior Living	\$ 37,117 1
2		
<b>Total</b>		<b>\$ 37,117 3</b>

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 of Robinson	2 Robinson

OTHER RELATED BUSINESS ENTITIES

Name	City	Type of Business
3	4	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: Wilkinson Corporation LLC If yes, what is the value of those services? \$ 14,847

(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: 01-01-2006

Ending: 12-31-2006

## VIII. OWNERSHIP COSTS

A. Purchase price of land 84,964 Year land was acquired 2005

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	35		2005	1999	\$ 2,357,875	\$		\$	\$	\$	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)				\$ 2,357,875	\$		\$	\$	\$	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	Furniture and Fixtures	\$ 106,914	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 106,914	\$	\$	24

Facility Name: Brookstone of Emerald Glen of Olney

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	<b>TOTAL</b>				\$			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			
	<b>A. Directly Facility Related Long-Term</b>									
1	GEMSA Loan Services		X	Mortgage	11/ /05	\$ 1,800,000	\$ 1,796,774	/ /		\$
2					/ /			/ /		
3	Fund VII	X		Notes	/ /	905,633	817,997	/ /		
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$ 2,705,633	\$ 2,614,771			\$
	<b>B. Non-Facility Related</b>									
8					/ /			/ /		
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 2,705,633	\$ 2,614,771			\$

\* 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.

## STATE OF ILLINOIS

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Facility Name: Brookstone of Emerald Glen of Olney  
 XI. BALANCE SHEET - Unrestricted Operating Fund.

Report Period Beginning: 01-01-2006  
 (last day of reporting year)

Ending: 12-31-2006 12-31-2006

As of 12-31-2006

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 3,831	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	76,418		3
4	Supply Inventory (priced at )	1,592		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,936		6
7	Other Prepaid Expenses	84,241		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Business Value</b>	20,573		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 190,591	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	84,964		13
14	Buildings, at Historical Cost	2,357,876		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	106,914		16
17	Accumulated Depreciation (book methods)	(81,665)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(9,937)		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>	\$ 2,458,152	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,648,743	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 154,456	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,350		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,211		30
31	Accrued Taxes Payable	31,612		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
<b>Other Current Liabilities(specify):</b>				
35	<b>Accrued Insurance</b>	(1,254)		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 210,375	\$	37
<b>D. Long-Term Liabilities</b>				
38	Long-Term Notes Payable	2,614,770		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
<b>Other Long-Term Liabilities(specify):</b>				
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 2,614,770	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 2,825,145	\$	45
46	<b>TOTAL EQUITY</b>	\$ (176,402)	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 2,648,743	\$	47

\*(See instructions.)

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 742,356	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 742,356	3
<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</b> (sum of lines 4 thru 10)	\$	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$	14
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	\$	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 742,356	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	193,302	19
20	Health Care/ Personal Care	120,749	20
21	General Administration	202,721	21
<b>B. Capital Expense</b>			
22	Ownership	359,064	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</b> (sum of lines 19 thru 27)	\$ 875,836	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ (133,480)	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ (133,480)	31