

Facility Name Brookstone of Emerald Glen of Olney

Report Period Beginning: 01/01/07 Ending: 12/31/07

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	35	Single Unit Apartment	35	12,775	1
2		Double Unit Apartment			2
3		Other			3
4	35	TOTALS	35	12,775	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	6,570	4,942		11,512	5
6	Double Unit					6
7	Other					7
8	TOTALS	6,570	4,942		11,512	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.11%

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

* 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.

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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	31,905	60,659		92,564		92,564	1
2	Housekeeping, Laundry and Maintenance	19,530	2,402	12,018	33,950		33,950	2
3	Heat and Other Utilities			52,249	52,249		52,249	3
4	Other (specify):		9,562		9,562		9,562	4
5	TOTAL General Services	51,435	72,623	64,267	188,325		188,325	5
B. Health Care and Programs								
6	Health Care/ Personal Care	131,919	562		132,481		132,481	6
7	Activities and Social Services							7
8	Other (not departmentalized):							8
9	TOTAL Health Care and Programs	131,919	562		132,481		132,481	9
C. General Administration								
10	Administrative and Clerical	41,577	1,899	24,646	68,122		68,122	10
11	Marketing Materials, Promotions and Advertising			7,916	7,916		7,916	11
12	Employee Benefits and Payroll Taxes	38,675			38,675		38,675	12
13	Insurance-Property, Liability and Malpractice			20,606	20,606		20,606	13
14	Other (other income/prior year adj):			16,977	16,977		16,977	14
15	TOTAL General Administration	80,252	1,899	70,145	152,296		152,296	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	263,606	75,084	134,412	473,102		473,102	16
Capital Expenses								
D. Ownership								
17	Depreciation							17
18	Interest							18
19	Real Estate Taxes			49,161	49,161		49,161	19
20	Rent -- Facility and Grounds			235,081	235,081		235,081	20
21	Rent -- Equipment			152	152		152	21
22	Other (specify): Management Fees			35,612	35,612		35,612	22
23	TOTAL Ownership			320,006	320,006		320,006	23
24	GRAND TOTAL (Sum of lines 16 and 23)	263,606	75,084	454,418	793,108		793,108	24

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses			1
2	Licensed Practical Nurses	1	19.00	2
3	Certified Nurse Assistants	6	7.65	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	2	7.93	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	7.65	10
11	Laundry			11
12	Managers	1	10.85	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	11	\$	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	\$	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).

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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

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IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: _____

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					/ /	\$		/ /		\$	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.

STATE OF ILLINOIS

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 842	\$	1
2	Security Deposits	1,000		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	83,716		3
4	Supply Inventory (priced at)	3,224		4
5	Short-Term Investments			5
6	Prepaid Insurance	8,230		6
7	Other Prepaid Expenses	1,389		7
8	Accounts Receivable (owners or related parties)	33,292		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 131,693	\$	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	996		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds - Escrows	65,839		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 66,835	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 198,528	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 135,222	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Resident Deposits	16,900		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,477		30
31	Accrued Taxes Payable	49,161		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes	478		34
Other Current Liabilities(specify):				
35	other PR tax liabilities	2,158		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 212,396	\$	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)	\$ 212,396	\$	45
46	TOTAL EQUITY	\$ (3,439)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 208,957	\$	47

*(See instructions.)

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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	\$ 766,741	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 766,741	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	Food Stamp Revenue	13,663	15
16	Miscellaneous	2,273	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 15,936	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 782,677	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	188,325	19
20	Health Care/ Personal Care	132,481	20
21	General Administration	152,296	21
B. Capital Expense			
22	Ownership	320,006	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)	\$ 793,108	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (10,431)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (10,431)	31