

Facility Name Brookstone of Emerald Glen of Olney

Report Period Beginning: 1/1/08 Ending: 12/31/08

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	12,810	1
2		Double Unit Apartment			2
3		Other			3
4	35	TOTALS	35	12,810	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	7,068	5,659		12,727	5
6	Double Unit					6
7	Other					7
8	TOTALS	7,068	5,659		12,727	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.35%

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	37,365	63,485		100,850		100,850	1
2	Housekeeping, Laundry and Maintenance	15,029	4,388	13,100	32,517		32,517	2
3	Heat and Other Utilities			57,487	57,487		57,487	3
4	Other (specify): Allocated (shared Maintenance)	12,764			12,764		12,764	4
5	TOTAL General Services	65,158	67,873	70,587	203,618		203,618	5
B. Health Care and Programs								
6	Health Care/ Personal Care	168,675	5		168,680		168,680	6
7	Activities and Social Services		1,765		1,765		1,765	7
8	Other (specify): Allocated							8
9	TOTAL Health Care and Programs	168,675	1,770		170,445		170,445	9
C. General Administration								
10	Administrative and Clerical	36,314	11,120	16,158	63,592		63,592	10
11	Marketing Materials, Promotions and Advertising			9,777	9,777		9,777	11
12	Employee Benefits and Payroll Taxes	33,438		48,884	82,322		82,322	12
13	Insurance-Property, Liability and Malpractice			13,730	13,730		13,730	13
14	Other (specify): Other income expense prior year			2,859	2,859		2,859	14
15	TOTAL General Administration	69,752	11,120	91,408	172,280		172,280	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	303,585	80,763	161,995	546,343		546,343	16
Capital Expenses								
D. Ownership								
17	Depreciation							17
18	Interest			220	220		220	18
19	Real Estate Taxes			51,063	51,063		51,063	19
20	Rent -- Facility and Grounds			248,709	248,709		248,709	20
21	Rent -- Equipment							21
22	Other (specify): Management Fees			47,233	47,233		47,233	22
23	TOTAL Ownership			347,225	347,225		347,225	23
24	GRAND TOTAL (Sum of lines 16 and 23)	303,585	80,763	509,220	893,568		893,568	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			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers	9.1	8.94	5
6	Head Cook			6
7	Cook Helpers/Assistants	2.2	8.07	7
8	Dishwashers			8
9	Maintenance Workers	0.1	10.00	9
10	Housekeepers	0.8	7.98	10
11	Laundry			11
12	Managers	0.8	13.33	12
13	Other Administrative	0.3	12.50	13
14	Clerical	0.2	16.18	14
15	Marketing			15
16	Other- Allocated	0.6	10.00	16
17	Total (lines 1 thru 16)	14.1	\$	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		\$

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	Leasehold Improvements				996	100	10		(100)		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)				\$ 996	\$ 100		\$	(100)	\$	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	\$	\$	\$	\$	7	\$	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: Wakefield Capital

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	Amount of Note				
							Original					
		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 12/31/08

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 840	\$	1
2	Cash-Security Deposits	2,000		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	113,452		3
4	Supply/Food Inventory (priced at 3 wks)	3,224		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,274		6
7	Other Prepaid Expenses	1,444		7
8	Accounts Receivable (1903 owners or related parties)	33,193		8
9	Other(specify): Intercompany Bal. Sheet True-up (1903)	(39,099)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 122,328	\$	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	4,847		15
16	Equipment, at Historical Cost	996		16
17	Accumulated Depreciation (book methods)	(100)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds-Escrow Deposits	40,754		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 46,497	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 168,825	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 51,670	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,250		28
29	Short-Term Notes Payable			29
30	Accrued Salaries & Taxes Payable	11,573		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Comp- Accrued Vacation & PTO	4,580		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accounts Payable- Interco			35
36	Property Taxes Payable	50,460		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 130,533	\$	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)	\$ 130,533	\$	45
46	TOTAL EQUITY	\$ (13,847)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 116,686	\$	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	\$ 904,524	1
2	Discounts and Allowances	(650)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 903,874	3
B. Other Operating Revenue			
4	Special Services- (Level of Care & Move in Fees)	20,633	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)	\$ 20,633	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	20,871	15
16	Miscellaneous	(201)	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 20,670	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 945,177	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	203,618	19
20	Health Care/ Personal Care	170,445	20
21	General Administration	172,280	21
B. Capital Expense			
22	Ownership	347,225	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify): Unallocated	(529)	25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 893,039	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 52,138	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 52,138	31