



Facility Name Brookstone Estates of Paris

Report Period Beginning: 1/1/09 Ending: 12/31/09

**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	46	Single Unit Apartment	46	16,790	1
2		Double Unit Apartment			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	8,583	8,428		17,011	5
6	Double Unit					6
7	Other					7
8	TOTALS	8,583	8,428		17,011	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 101.32%

**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)

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**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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	69,158	77,016		146,174		146,174	1
2	Housekeeping, Laundry and Maintenance	52,679	2,337	18,756	73,772		73,772	2
3	Heat and Other Utilities			71,196	71,196		71,196	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>121,837</b>	<b>79,353</b>	<b>89,952</b>	<b>291,142</b>		<b>291,142</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	111,726			111,726		111,726	6
7	Activities and Social Services		2,029		2,029		2,029	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>111,726</b>	<b>2,029</b>		<b>113,755</b>		<b>113,755</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	56,896	8,828	12,275	77,999		77,999	10
11	Marketing Materials, Promotions and Advertising			10,890	10,890		10,890	11
12	Employee Benefits and Payroll Taxes	21,680		53,436	75,116		75,116	12
13	Insurance-Property, Liability and Malpractice			12,482	12,482		12,482	13
14	(specify)			1,769	1,769		1,769	14
15	<b>TOTAL General Administration</b>	<b>78,576</b>	<b>8,828</b>	<b>90,852</b>	<b>178,256</b>		<b>178,256</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>312,139</b>	<b>90,210</b>	<b>180,804</b>	<b>583,153</b>		<b>583,153</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			320	320		320	17
18	Interest			45	45		45	18
19	Real Estate Taxes			59,902	59,902		59,902	19
20	Rent -- Facility and Grounds			703,286	703,286		703,286	20
21	Rent -- Equipment			1,123	1,123		1,123	21
22	(specify) Management fees			71,428	71,428		71,428	22
23	<b>TOTAL Ownership</b>			<b>836,104</b>	<b>836,104</b>		<b>836,104</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>312,139</b>	<b>90,210</b>	<b>1,016,908</b>	<b>1,419,257</b>		<b>1,419,257</b>	<b>24</b>

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.7	\$ 20.76	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers	4.7	8.12	5
6	Head Cook			6
7	Cook Helpers/Assistants	3.9	8.54	7
8	Dishwashers			8
9	Maintenance Workers	1.2	11.95	9
10	Housekeepers	1.4	7.61	10
11	Laundry			11
12	Managers	1.1	14.09	12
13	Other Administrative			13
14	Clerical	1.0	11.48	14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>14.0</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				\$	1	
2					2	
3					3	
4					4	
5					5	
				<b>Total</b>	<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

		Amount of Fee		
1	Good Neighbor Care LLC (listed on pg 3, line 22)	\$ 71,428	1	
2			2	
		<b>Total</b>	<b>\$ 71,428</b>	<b>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	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
<b>Improvement Type</b>											
6	Leasehold Improvements		2009		3,320	300	10		(300)	300	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)				\$ 3,320	\$ 300		\$	(300)	\$ 300	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	\$ 1,619	\$ 20	\$	(20)	7	\$ 20	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 1,619	\$ 20	\$	(20)		\$ 20	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: 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	<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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		<b>A. Directly Facility Related</b>										
		<b>Long-Term</b>										
1						/ /	\$	\$	/ /		\$	1
2						/ /			/ /			2
3						/ /			/ /			3
		<b>Working Capital</b>										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		<b>TOTAL Facility Related</b>					\$	\$			\$	7
		<b>B. Non-Facility Related</b>										
8						/ /			/ /			8
9						/ /			/ /			9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$	\$			\$	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.

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## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash- Security Deposits	14,556		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	158,577		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,770		6
7	Other Prepaid Expenses	1,255		7
8	Accounts Receivable (1903 owners or related parties)			8
9	Other(specify): Intercompany Bal. Sheet True-up (1902)			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 177,158	\$	10
	<b>B. Long-Term Assets</b>			
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	3,320		15
16	Equipment, at Historical Cost	786		16
17	Accumulated Depreciation (book methods)	(320)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	55,861		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>	\$ 59,647	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 236,805	\$	25

\*(See instructions.)

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 48,411	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(25,421)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,448		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation	12,281		33
34	Income Taxes	6,960		34
	<b>Other Current Liabilities(specify):</b>			
35	Accounts Payable- Interco	77,329		35
36	Property Taxes Payable	59,902		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 193,910	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			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>	\$	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 193,910	\$	45
46	<b>TOTAL EQUITY</b>	\$ 42,895	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 236,805	\$	47

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## 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	\$ 1,365,665	1
2	Discounts and Allowances	(11,637)	2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	<b>\$ 1,354,028</b>	3
<b>B. Other Operating Revenue</b>			
4	Special Services- (Level of Care & Move in Fees)	44,844	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)	<b>\$ 44,844</b>	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)	<b>\$</b>	14
<b>D. Other Revenue (specify):</b>			
15	Food Stamp Revenue	33,886	15
16	Miscellaneous	3,649	16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	<b>\$ 37,535</b>	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	<b>\$ 1,436,407</b>	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	291,142	19
20	Health Care/ Personal Care	113,755	20
21	General Administration	178,256	21
<b>B. Capital Expense</b>			
22	Ownership	836,104	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)	<b>\$ 1,419,257</b>	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	<b>\$ 17,150</b>	29
30	<b>Income Taxes</b>	<b>\$ 6,960</b>	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	<b>\$ 10,190</b>	31