

Facility Name Brookstone Estates of Tuscola

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	5,724	12,548		18,272	5
6	Double Unit					6
7	Other					7
8	TOTALS	5,724	12,548		18,272	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 108.83%

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	98,286	87,165		185,451		185,451	1
2	Housekeeping, Laundry and Maintenance	15,160	13,671	17,003	45,834		45,834	2
3	Heat and Other Utilities			72,927	72,927		72,927	3
4	Other (specify):							4
5	TOTAL General Services	113,446	100,836	89,930	304,212		304,212	5
B. Health Care and Programs								
6	Health Care/ Personal Care	117,988			117,988		117,988	6
7	Activities and Social Services		2,457		2,457		2,457	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	117,988	2,457		120,445		120,445	9
C. General Administration								
10	Administrative and Clerical	64,359	6,718	13,580	84,657		84,657	10
11	Marketing Materials, Promotions and Advertising			7,153	7,153		7,153	11
12	Employee Benefits and Payroll Taxes	24,997		56,015	81,012		81,012	12
13	Insurance-Property, Liability and Malpractice			11,455	11,455		11,455	13
14	Other (specify): Prior year adjustments			1,788	1,788		1,788	14
15	TOTAL General Administration	89,356	6,718	89,991	186,065		186,065	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	320,790	110,011	179,921	610,722		610,722	16
Capital Expenses								
D. Ownership								
17	Depreciation			3,758	3,758		3,758	17
18	Interest			904	904		904	18
19	Real Estate Taxes			76,540	76,540		76,540	19
20	Rent -- Facility and Grounds			536,203	536,203		536,203	20
21	Rent -- Equipment			497	497		497	21
22	Other (specify): Management fees			70,200	70,200		70,200	22
23	TOTAL Ownership			688,102	688,102		688,102	23
24	GRAND TOTAL (Sum of lines 16 and 23)	320,790	110,011	868,023	1,298,824		1,298,824	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	0.6	\$ 21.61	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers	4.5	11.22	5
6	Head Cook			6
7	Cook Helpers/Assistants	5.0	9.52	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	0.8	8.94	10
11	Laundry			11
12	Managers	1.0	19.97	12
13	Other Administrative			13
14	Clerical	0.9	12.45	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	12.8	\$	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	Good Neighbor Care LLC (listed on pg 3, line 22)	\$ 70,200	1	
2			2	
		Total	\$ 70,200	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	Leasehold Improvements										
7							10				6
8											7
9											8
10											9
11											10
12											11
13											12
14											13
15											14
16											15
17	TOTAL (lines 1 thru 16)										
					\$	\$		\$	\$	\$	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	\$ 863	\$ 11	\$	(11)	7	\$ 11	18
19	Vehicles	12,129	3,747		(3,747)		3,747	19
20	TOTAL (lines 18 and 19)	\$ 12,992	\$ 3,758	\$	(3,758)		\$ 3,758	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	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**				Purpose of Loan	Date of Note					Amount of Note
			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.

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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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Security Deposits	2,100		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	122,492		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,941		6
7	Other Prepaid Expenses	72		7
8	Accounts Receivable (1903 owners or related parties)			8
9	Other(specify): Intercompany Bal. Sheet True-up (1902)			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 127,605	\$	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	12,129		16
17	Accumulated Depreciation (book methods)	(3,758)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	55,787		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 64,158	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 191,763	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 39,369	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,643		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,449		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation	9,557		33
34	Income Taxes	40,674		34
	Other Current Liabilities(specify):			
35	Accounts Payable- Interco	347		35
36	Property Taxes Payable	66,576		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 200,615	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	8,412		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)	\$ 8,412	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 209,027	\$	45
46	TOTAL EQUITY	\$ (17,264)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 191,763	\$	47

*(See instructions.)

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

	1	Amount	
Revenue			
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,346,537	1
2	Discounts and Allowances	(28,236)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,318,301	3
B. Other Operating Revenue			
4	Special Services- (Level of Care & Move in Fees)	67,015	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)	\$ 67,015	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	14,540	15
16	Miscellaneous	1,216	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 15,756	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,401,072	18

	2	Amount	
Expenses			
A. Operating Expenses			
19	General Services	304,212	19
20	Health Care/ Personal Care	120,445	20
21	General Administration	186,065	21
B. Capital Expense			
22	Ownership	688,102	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)	\$ 1,298,824	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 102,248	29
30	Income Taxes	\$ 40,674	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 61,574	31