

Facility Name Brookstone Estates of Paris

Report Period Beginning: 1/1/10 Ending: 12/31/10

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		1,386	3
4	46	TOTALS	46	18,176	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	7,125	9,750		16,875	5
6	Double Unit					6
7	Other					7
8	TOTALS	7,125	9,750		16,875	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.84%

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 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	81,288	82,219		163,507		163,507	1
2	Housekeeping, Laundry and Maintenance	53,143	954	15,511	69,608		69,608	2
3	Heat and Other Utilities			63,301	63,301	(7,915)	55,386	3
4	Other (specify): Waste Disposal			1,295	1,295		1,295	4
5	TOTAL General Services	134,431	83,173	80,107	297,711	(7,915)	289,796	5
B. Health Care and Programs								
6	Health Care/ Personal Care	109,964	524		110,488		110,488	6
7	Activities and Social Services		2,140		2,140		2,140	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	109,964	2,664		112,628		112,628	9
C. General Administration								
10	Administrative and Clerical	49,755	13,196	19,252	82,203		82,203	10
11	Marketing Materials, Promotions and Advertising			10,514	10,514		10,514	11
12	Employee Benefits and Payroll Taxes			90,651	90,651		90,651	12
13	Insurance-Property, Liability and Malpractice			11,411	11,411		11,411	13
14	Other (specify): PY Adj, Internet, Interest Income			(3,643)	(3,643)		(3,643)	14
15	TOTAL General Administration	49,755	13,196	128,184	191,135		191,135	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	294,150	99,033	208,291	601,474	(7,915)	593,559	16
Capital Expenses								
D. Ownership								
17	Depreciation			777	777		777	17
18	Interest			282	282		282	18
19	Real Estate Taxes			62,077	62,077		62,077	19
20	Rent -- Facility and Grounds			707,671	707,671		707,671	20
21	Rent -- Equipment			576	576		576	21
22	Other (specify): Mgmt Fee, Income Tax, Tax Penalty			159,278	159,278	(81,163)	78,115	22
23	TOTAL Ownership			930,662	930,662	(81,163)	849,499	23
24	GRAND TOTAL (Sum of lines 16 and 23)	294,150	99,033	1,138,953	1,532,136	(89,078)	1,443,058	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	0.7	\$ 22.51	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers	5.0	8.84	5
6	Head Cook			6
7	Cook Helpers/Assistants	4.6	9.12	7
8	Dishwashers			8
9	Maintenance Workers	1.2	16.54	9
10	Housekeepers	1.0	8.29	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.0	14.05	13
14	Clerical	1.0	12.07	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	14.5	\$	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 (JAN - JUL)	\$ 42,445	1
2	Meridian Senior Living (AUG - DEC)	\$ 35,670	2
Total		\$ 78,115	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: 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

	Name of Lender	2		3	4	6		7	8	9						
		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.

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 15,052	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	88,816		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,123		6
7	Other Prepaid Expenses	6,134		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 117,125	\$	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			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	76,142		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 76,142	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 193,267	\$	25

*(See instructions.)

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,100		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,776		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Property Taxes Payable/Accrued Exp	63,949		35
36	Accounts Payable (owners/related parties)	6,375		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 126,200	\$	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)	\$ 126,200	\$	45
46	TOTAL EQUITY	\$ 67,067	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 193,267	\$	47

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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	\$ 1,468,581	1
2	Discounts and Allowances	(34,354)	2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 1,434,228	3
B. Other Operating Revenue			
4	Special Services (Move-in Fees)	5,300	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
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 5,300	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15	Food Stamp Revenue	33,306	15
16	Miscellaneous	775	16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 34,081	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,473,609	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	289,796	19
20	Health Care/ Personal Care	112,628	20
21	General Administration	191,135	21
B. Capital Expense			
22	Ownership	849,499	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 1,443,058	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 30,550	29
Income Taxes			
30		\$ 81,163	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (50,613)	31

000	105	Interest Income-Paris	121.08-
000	105	Utilities - internet service-Paris	953.37
000	105	Other Income/Expense - Prior Year Adj-Paris	4,475.48-
			3,643.19- 14 Other

000	105	Management Fees-Paris	78,115.27
000	105	Income Tax Exp-Paris	80,735.58
000	105	Tax Penalties-Paris	427.45
			159,278.30 22 Other (specify):