

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units n/a

	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	3,620	12,810		16,430	5
6	Double Unit					6
7	Other					7
8	TOTALS	3,620	12,810		16,430	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 100.00%

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: 2012 Fiscal Year: 2012

* 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. _____

STATE OF ILLINOIS

Page 3

Facility Name: Brookstone of Emerald Glen of Olney

ID#:

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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	19,977	68,844	2,217	91,037		91,037	1
2	Housekeeping, Laundry and Maintenance	40,480	7,596	1,457	49,532		49,532	2
3	Heat and Other Utilities			41,791	41,791		41,791	3
4	Other (specify): Repairs / Maintenance			5,682	5,682		5,682	4
5	TOTAL General Services	60,457	76,439	51,147	188,043		188,043	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	152,056	2,663	226	154,946		154,946	6
7	Activities and Social Services	448	448	340	1,236		1,236	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	152,504	3,111	566	156,182		156,182	9
	C. General Administration							
10	Administrative and Clerical	53,209	3,407	36,187	92,803		92,803	10
11	Marketing Materials, Promotions and Advertising			13,366	13,366		13,366	11
12	Employee Benefits and Payroll Taxes			54,814	54,814		54,814	12
13	Insurance-Property, Liability and Malpractice			28,533	28,533		28,533	13
14	Other (specify): Management Fees			49,463	49,463		49,463	14
15	TOTAL General Administration	53,209	3,407	182,362	238,978		238,978	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	266,170	82,958	234,076	583,203		583,203	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			3,202	3,202		3,202	17
18	Interest							18
19	Real Estate Taxes			55,378	55,378		55,378	19
20	Rent -- Facility and Grounds			304,283	304,283		304,283	20
21	Rent -- Equipment			2,373	2,373		2,373	21
22	Other (specify):							22
23	TOTAL Ownership			365,237	365,237		365,237	23
24	GRAND TOTAL (Sum of lines 16 and 23)	266,170	82,958	599,312	948,440		948,440	24

Facility Name: Brookstone of Emerald Glen of Olney

ID#:

Report Period Beginning 1/1/2012

Ending:

12/31/2012

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	28.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers	9	\$ 10.05	5
6	Head Cook	1	12.25	6
7	Cook Helpers/Assistants	2	9.10	7
8	Dishwashers			8
9	Maintenance Workers	1	12.00	9
10	Housekeepers	1	9.20	10
11	Laundry			11
12	Managers	3	10.40	12
13	Other Administrative			13
14	Clerical	1	8.60	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	19	\$	17

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).

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	Meridian Senior Living	\$	49,463	1
2				2
Total		\$	49,463	3

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

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 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 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

Page 7

Facility Name: Brookstone of Emerald Glen of Olney

ID#:

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 124,537	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	251,121		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,765		6
7	Other Prepaid Expenses	142		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 379,565	\$	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	28,556		16
17	Accumulated Depreciation (book methods)	(3,845)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 24,710	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 404,276	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 42,458	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,539		30
31	Accrued Taxes Payable	1,054		31
32	Accrued Interest Payable			32
33	Deferred Compensation	5,391		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 59,442	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	25,872		38
39	Mortgage Payable			39
40	BTnds 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)	\$ 25,872	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 85,313	\$	45
46	TOTAL EQUITY	\$ 318,963	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 404,276	\$	47

*(See instructions.)

Facility Name: Brookstone of Emerald Glen of Olney

ID#:

Report Period Beginning: 1/1/2012

Ending:

12/31/2012

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

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,015,639	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,015,639	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services	338	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)	\$ 338	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	4,133	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 4,133	14
	D. Other Revenue (specify):		
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,020,111	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	188,141	19
20	Health Care/ Personal Care	192,573	20
21	General Administration	259,792	21
	B. Capital Expense		
22	Ownership	307,486	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)	\$ 947,992	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 72,119	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 72,119	31