

Facility Name QUINCY SENIOR AND FAMILY RESOURCE CENTERReport Period Beginning: 01/01/2006 Ending: 12/31/2006

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	51	Single Unit Apartment	51	18,615	1
2	6	Double Unit Apartment	6	2,190	2
3		Other			3
4	57	TOTALS	57	20,805	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	15,147	3,212		18,359	5
6	Double Unit	1,076	1,059		2,135	6
7	Other					7
8	TOTALS	16,223	4,271		20,494	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.51% D. Indicate the number of paid bed-hold days the SLF had during this year 311 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 311 (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)

N/A

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* I. Is your fiscal year identical to your tax year? YES NOTax Year: JAN - DEC Fiscal Year: JAN - DEC

* 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		211,110		211,110		211,110	1
2	Housekeeping, Laundry and Maintenance	54,779	56,355		111,134		111,134	2
3	Heat and Other Utilities			55,059	55,059	10,032	65,091	3
4	Other (specify):							4
5	TOTAL General Services	54,779	267,465	55,059	377,303	10,032	387,335	5
B. Health Care and Programs								
6	Health Care/ Personal Care	372,651	8,576		381,227		381,227	6
7	Activities and Social Services		18,077	2,570	20,647		20,647	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	372,651	26,653	2,570	401,874		401,874	9
C. General Administration								
10	Administrative and Clerical	50,025	6,226	5,421	61,672		61,672	10
11	Marketing Materials, Promotions and Advertising			1,022	1,022		1,022	11
12	Employee Benefits and Payroll Taxes	184,476			184,476		184,476	12
13	Insurance-Property, Liability and Malpractice	29,727			29,727		29,727	13
14	Other (specify):							14
15	TOTAL General Administration	264,228	6,226	6,443	276,897		276,897	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	691,658	300,343	64,072	1,056,074	10,032	1,066,106	16
Capital Expenses								
D. Ownership								
17	Depreciation			276,015	276,015		276,015	17
18	Interest			314,431	314,431		314,431	18
19	Real Estate Taxes			130	130		130	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Mortgage Premium Insurance			20,753	20,753		20,753	22
23	TOTAL Ownership			611,329	611,329		611,329	23
24	GRAND TOTAL (Sum of lines 16 and 23)	691,658	300,343	675,401	1,667,403	10,032	1,677,435	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	\$ 22.00	1
2	Licensed Practical Nurses	2	15.00	2
3	Certified Nurse Assistants	13	9.00	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	3	7.00	10
11	Laundry	1	7.00	11
12	Managers	1	14.90	12
13	Other Administrative			13
14	Clerical	1	9.60	14
15	Marketing			15
16	Other	5	6.75	16
17	Total (lines 1 thru 16)	27	\$ 11.41	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		\$ 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 <u>1</u>	City <u>2</u>
NDC EQUITY FUNDS IV	NEW YORK, NY

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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		2002	2002	\$ 7,006,426	\$	25	\$ 276,015	\$ 276,015	\$ 973,843	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)				\$ 7,006,426	\$		\$ 276,015	\$ 276,015	\$ 973,843	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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Ending: **2/31/2006**

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	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	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					/ /	\$		/ /		\$
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$				\$
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$				\$

* 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 12/31/2006

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 182,419	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	9,641		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,995		7
8	Accounts Receivable (owners or related parties)	254,114		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 459,169	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,920,363		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	164,345		16
17	Accumulated Depreciation (book methods)	(973,843)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	234,419		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Unamortized Mortgage loan</u>	555,414		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,900,698	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,359,867	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 29,746	\$	26
27	Officer's Accounts Payable	115,262		27
28	Accounts Payable-Patient Deposits	4,261		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,770		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	26,131		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Current Maturities on Mortgage loan</u>	22,264		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 244,434	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	640,233		38
39	Mortgage Payable	4,103,675		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	<u>Development Fee</u>	222,629		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 4,966,537	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,210,971	\$	45
46	TOTAL EQUITY	\$ 2,148,896	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,359,867	\$	47

*(See instructions.)

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	\$ 714,564	1
2	Discounts and Allowances	30,351	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 744,915	3
B. Other Operating Revenue			
4	Special Services	612,474	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)	\$ 612,474	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			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)	\$ 1,357,389	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	58,929	19
20	Health Care/ Personal Care	944,834	20
21	General Administration	82,038	21
B. Capital Expense			
22	Ownership	394,049	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):	3,672	25
26	Depreciation	276,015	26
27	Amortization	20,393	27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 1,779,930	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (422,541)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (422,541)	31

Page 3

Line 3, Column 5

\$10,032 is the amount for cable to resident rooms.

Line 7, Column 3

\$2570 is the amount paid for personal care services located outside of the facility