

Facility Name Magnolia Terrace

Report Period Beginning: 12/01/2006 Ending: 11/30/2007

III. STATISTICAL DATA

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

Date of change in certified units 12/1/2006

	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	43	Single Unit Apartment	43	15,695	1
2	7	Double Unit Apartment	7	2,555	2
3		Other			3
4	50	TOTALS	50	18,250	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	4,136	6,594		10,730	5
6	Double Unit		1,421		1,421	6
7	Other					7
8	TOTALS	4,136	8,015		12,151	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 66.58%

D. Indicate the number of paid bed-hold days the SLF had during this year 595 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)

N/A

H. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: 11/30/2007 Fiscal Year: 11/30/2007

* 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. No loans outstanding

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. No loans outstanding

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. No loans outstanding

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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	66,209	60,836		127,045		127,045	1
2	Housekeeping, Laundry and Maintenance	55,272	8,013	12,166	75,451		75,451	2
3	Heat and Other Utilities			90,778	90,778		90,778	3
4	Other (specify):							4
5	TOTAL General Services	121,481	68,849	102,944	293,274		293,274	5
B. Health Care and Programs								
6	Health Care/ Personal Care	235,015	206	1,857	237,078		237,078	6
7	Activities and Social Services	27,786	3,153	904	31,843		31,843	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	262,801	3,359	2,761	268,921		268,921	9
C. General Administration								
10	Administrative and Clerical	38,403	7,627	40,154	86,184	(1,718)	84,466	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			135,887	135,887		135,887	12
13	Insurance-Property, Liability and Malpractice			56,961	56,961		56,961	13
14	Other (specify): Fees, Training, Travel, Misc.			486,237	486,237	(478,629)	7,608	14
15	TOTAL General Administration	38,403	7,627	719,239	765,269	(480,347)	284,922	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	422,685	79,835	824,944	1,327,464	(480,347)	847,117	16
Capital Expenses								
D. Ownership								
17	Depreciation			582	582	106,469	107,051	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			582	582	106,469	107,051	23
24	GRAND TOTAL (Sum of lines 16 and 23)	422,685	79,835	825,526	1,328,046	(373,878)	954,168	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	1.00	\$ 21.84	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.20	12.13	3
4	Activity Director & Assistants	1.14	11.03	4
5	Social Service Workers			5
6	Head Cook	2.00	9.97	6
7	Cook Helpers/Assistants	1.70	7.73	7
8	Dishwashers			8
9	Maintenance Workers	0.80	11.22	9
10	Housekeepers	1.70	8.41	10
11	Laundry	0.20	7.95	11
12	Managers	1.00	23.08	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	16.74	\$	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		\$

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
Oak Hill		Waterloo	

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 COSTSA. Purchase price of land N/A Year land was acquired N/A

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			2007	2007	\$ 7,070,025	\$ 106,469		\$ 106,469	\$	\$ 106,469	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Light Fixtures		2007	2007	1,644	235	7	235		235	6
7	Laundry Room		2007	2007	1,145	164	7	164		164	7
8	Washer & Dryer		2007	2007	1,280	183	7	183		183	8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 7,074,094	\$ 107,051		\$ 107,051	\$	\$ 107,051	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	\$ N/A	\$	\$	\$		\$	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		\$ N/A	\$	\$	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: N/A

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 \$ N/A

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	N/A				/ /	\$	\$	/ /		\$
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4	N/A				/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$	\$			\$
	B. Non-Facility Related									
8	N/A				/ /			/ /		
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.

Facility Name: **Magnolia Terrace**Report Period Beginning: **12/01/2006**Ending: **11/30/2007****11/30/2007****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **11/30/2007**

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 1,345,562	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		1,946,437	3
4	Supply Inventory (priced at)		19,647	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		27,392	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 3,339,038	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		6,793,542	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,319,747	16
17	Accumulated Depreciation (book methods)		(5,808,905)	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)	\$	\$ 2,304,384	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 5,643,422	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 99,870	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable		330,742	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
Other Current Liabilities(specify):				
35	Advance Billing, Due To, Etc		1,296,975	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$	\$ 1,727,587	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)	\$	\$ 1,727,587	45
46	TOTAL EQUITY	\$	\$ 3,915,835	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$	\$ 5,643,422	47

*(See instructions.)

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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	\$ 1,154,188	1
2	Discounts and Allowances	(123,598)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,030,590	3
B. Other Operating Revenue			
4	Special Services	1,303	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)	\$ 1,303	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 Income	5,772	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 5,772	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,037,665	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	555,344	19
20	Health Care/ Personal Care		20
21	General Administration	772,701	21
B. Capital Expense			
22	Ownership		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)	\$ 1,328,045	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (290,380)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (290,380)	31