FOR BHF USE

LL2

# Supportive Living Facility

## 2017
## STATE OF ILLINOIS
## DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
## COST REPORT FOR
## SUPPORTIVE LIVING FACILITIES
## (FISCAL YEAR 2017)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

**I. Facility ID Number:** 1000150

**Facility Name:** LACEY CREEK

**Address:** 4800 LACEY ROAD (Number) DOWNERS GROVE (City) 60515 (Zip Code)

**County:** DUPAGE

**Telephone Number:** ( 630 ) 964-7720 **Fax #** 630 964-4229

**Federal Employer ID Number:**

**Date Current Owners were Certified:** 8/23/2017

**Type of Ownership:**

| | | |
|---|---|---|
| [ ] VOLUNTARY, NON-PROFIT | [ ] PROPRIETARY | [ ] GOVERNMENTAL |
| [ ] Charitable Corp. | [ ] Individual | [ ] State |
| [ ] Trust | [ ] Partnership | [ ] County |
| IRS Exemption Code | [ ] Corporation | [ ] Other |
| | [ ] "Sub-S" Corp. | |
| | [X] Limited Liability Co. | |
| | [ ] Trust | |
| | [ ] Other | |

**In the event there are further questions about this report, please contact:**
**Name:** Thomas Staszak **Telephone Number:** (815) 935-1992
**Email Address:**

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2017 to 12/31/2017 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

**Officer or Administrator of Provider**
(Signed)
(Date)
(Type or Print Name) Greg Echols
(Title) CFO, Gardant Management Solutions

**Paid Preparer**
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
IL DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name LACEY CREEK Report Period Beginning: 01/01/2017 Ending: 12/31/2017

## III. STATISTICAL DATA

**A. Certified units; enter number of units and unit days**
Date of change in certified units / /

| | 1 Units at Beginning of Report Period | 2 Type of Apartment | 3 Units at End of Report Period | 4 Unit Days During Report Period | |
|---|---|---|---|---|---|
| 1 | 120 | Single Unit Apartment | 120 | 43,800 | 1 |
| 2 | | Double Unit Apartment | | | 2 |
| 3 | | Other | | | 3 |
| 4 | 120 | TOTALS | 120 | 43,800 | 4 |

**B. Census-For the entire report period.**

| | 1 Type of Unit | 2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient | 3 Private Pay | 4 Other | 5 Total | |
|---|---|---|---|---|---|---|
| 5 | Single Unit | 26,821 | 8,493 | | 35,314 | 5 |
| 6 | Double Unit | | | | | 6 |
| 7 | Other | | | | | 7 |
| 8 | TOTALS | 26,821 | 8,493 | | 35,314 | 8 |

**C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.)** 80.63%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 843 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 41 **(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 [X]

**F. Does the BALANCE SHEET reflect any non-SLF assets?**
YES [ ] NO [X]

**G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)**

**H. ACCOUNTING BASIS**
ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

**I. Is your fiscal year identical to your tax year?** [X] YES [ ] NO
Tax Year: 2017 Fiscal Year: 2017
* 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.**

**Facility Name: LACEY CREEK** **Report Period Beginning: 01/01/2017 Ending: 12/31/2017**

**IV. COST CENTER EXPENSES (please round to the nearest dollar)**

| | Operating Expenses | Costs Per General Ledger | | | | Reclassifications and Adjustments | Adjusted Total | |
|---|---|---|---|---|---|---|---|---|
| | | Salary/Wage | Supplies | Other | Total | | | |
| | **A. General Services** | 1 | 2 | 3 | 4 | 5 | 6 | |
| 1 | Dietary and Food Purchase | 267,100 | 185,253 | 1,799 | 454,152 | | 454,152 | 1 |
| 2 | Housekeeping, Laundry and Maintenance | 100,461 | 21,039 | 39,164 | 160,664 | | 160,664 | 2 |
| 3 | Heat and Other Utilities | | | 207,587 | 207,587 | (18,748) | 188,839 | 3 |
| 4 | Other (specify): See Page 3 Attachment | | | 11,538 | 11,538 | | 11,538 | 4 |
| 5 | **TOTAL General Services** | 367,561 | 206,292 | 260,088 | 833,941 | (18,748) | 815,193 | 5 |
| | **B. Health Care and Programs** | | | | | | | |
| 6 | Health Care/ Personal Care | 513,558 | 11,563 | | 525,121 | | 525,121 | 6 |
| 7 | Activities and Social Services | 36,004 | 11,104 | | 47,108 | | 47,108 | 7 |
| 8 | Other (specify): | | | | | | | 8 |
| 9 | **TOTAL Health Care and Programs** | 549,562 | 22,667 | | 572,229 | | 572,229 | 9 |
| | **C. General Administration** | | | | | | | |
| 10 | Administrative and Clerical | 191,676 | 28,803 | 273,550 | 494,029 | (26,879) | 467,150 | 10 |
| 11 | Marketing Materials, Promotions and Advertising | 68,798 | 14,543 | 38,164 | 121,505 | | 121,505 | 11 |
| 12 | Employee Benefits and Payroll Taxes | | | 237,496 | 237,496 | | 237,496 | 12 |
| 13 | Insurance-Property, Liability and Malpractice | | | 64,493 | 64,493 | | 64,493 | 13 |
| 14 | Other (specify): See Page 3 Attachment | | | 111,670 | 111,670 | (26,411) | 85,259 | 14 |
| 15 | **TOTAL General Administration** | 260,474 | 43,346 | 725,373 | 1,029,193 | (53,290) | 975,903 | 15 |
| 16 | **TOTAL Operating Expense (Sum of lines 5, 9 and 15)** | 1,177,597 | 272,305 | 985,461 | 2,435,363 | (72,038) | 2,363,325 | 16 |
| | **Capital Expenses** | | | | | | | |
| | **D. Ownership** | | | | | | | |
| 17 | Depreciation | | | 610,858 | 610,858 | | 610,858 | 17 |
| 18 | Interest | | | 880,335 | 880,335 | (2,874) | 877,461 | 18 |
| 19 | Real Estate Taxes | | | 183,750 | 183,750 | | 183,750 | 19 |
| 20 | Rent -- Facility and Grounds | | | | | | | 20 |
| 21 | Rent -- Equipment | | | 12,223 | 12,223 | | 12,223 | 21 |
| 22 | Other (specify): See Page 3 Attachment | | | 60,042 | 60,042 | (3,000) | 57,042 | 22 |
| 23 | **TOTAL Ownership** | | | 1,747,208 | 1,747,208 | (5,874) | 1,741,334 | 23 |
| 24 | **GRAND TOTAL (Sum of lines 16 and 23)** | 1,177,597 | 272,305 | 2,732,669 | 4,182,571 | (77,912) | 4,104,659 | 24 |

Facility Name: LACEY CREEK Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

| | Personnel | Number of FTE | Average Hourly Wage | |
|---|---|---|---|---|
| 1 | Registered Nurses | Inc line 12 | $ Inc line 12 | 1 |
| 2 | Licensed Practical Nurses | 1 | 25.51 | 2 |
| 3 | Certified Nurse Assistants | 14 | 12.37 | 3 |
| 4 | Activity Director & Assistants | Inc line 12 | Inc line 12 | 4 |
| 5 | Social Service Workers | | | 5 |
| 6 | Head Cook | | | 6 |
| 7 | Cook Helpers/Assistants | 9 | 11.18 | 7 |
| 8 | Dishwashers | | | 8 |
| 9 | Maintenance Workers | Inc line 12 | Inc line 12 | 9 |
| 10 | Housekeepers | 2 | 10.14 | 10 |
| 11 | Laundry | | | 11 |
| 12 | Managers | 5 | 25.35 | 12 |
| 13 | Other Administrative | 5 | 22.29 | 13 |
| 14 | Clerical | Inc line 13 | Inc line 13 | 14 |
| 15 | Marketing | Inc line 12 | Inc line 12 | 15 |
| 16 | Other | | | 16 |
| 17 | Total (lines 1 thru 16) | 36 | $ | 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 | Gardant Management Solutions | $ 195,365 | 1 |
| 2 | | | 2 |
| | | Total $ 195,365 | 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 | | | | OTHER RELATED BUSINESS ENTITIES | | | | |
|---|---|---|---|---|---|---|---|---|
| Name | 1 | City | 2 | 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 [X]
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 [X]
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).

Facility Name: LACEY CREEK Report Period Beginning: 01/01/2017 Ending: 12/31/2017

## VIII. OWNERSHIP COSTS

A. Purchase price of land $ 2,168,346 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 | 120 | | | | $ 19,756,540 | $ 493,160 | 40 | $ 493,913 | $ 753 | $ 575,545 | 1 |
| 2 | | | | | | | | | | | 2 |
| 3 | | | | | | | | | | | 3 |
| 4 | | | | | | | | | | | 4 |
| 5 | | | | | | | | | | | 5 |
| | Improvement Type | | | | | | | | | | |
| 6 | Leasehold Improvements | | | | 1,748,622 | 87,432 | 20 | 87,431 | (1) | 102,004 | 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) | | | | $ 21,505,162 | $ 580,592 | | $ 581,345 | $ 753 | $ 677,549 | 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 | $ 1,175,885 | $ 18,266 | $ | (18,266) | 10 | $ 35,172 | 18 |
| 19 | Vehicles | 59,990 | 12,000 | | (12,000) | 5 | 13,000 | 19 |
| 20 | TOTAL (lines 18 and 19) | $ 1,235,874 | $ 30,266 | $ | (30,266) | | $ 48,172 | 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 |

**Facility Name:** LACEY CREEK **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

## 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 Name of Lender | 2 Related** YES | 2 Related** NO | 3 Purpose of Loan | 4 Date of Note | 6 Amount of Note Original | 6 Amount of Note Balance | 7 Maturity Date | 8 Interest Rate (4 Digits) | 9 Reporting Period Int. Expense | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | A. Directly Facility Related Long-Term | | | | | | | | | | |
| 1 | Heartland Bank & Trust | | | | 12/30/2014 | $ 20,114,920 | $ 20,114,920 | 12/1/2032 | 5.6150 | $ 880,335 | 1 |
| 2 | Heartland Bank & Trust | | | | 12/30/2014 | 835,080 | 835,080 | 12/1/2032 | 5.6150 | | 2 |
| 3 | | | | | | | | | | | 3 |
| | Working Capital | | | | | | | | | | |
| 4 | | | | | / / | | | / / | | | 4 |
| 5 | | | | | / / | | | / / | | | 5 |
| 6 | | | | | / / | | | / / | | | 6 |
| 7 | TOTAL Facility Related | | | | | $ 20,950,000 | $ 20,950,000 | | | $ 880,335 | 7 |
| | B. Non-Facility Related | | | | | | | | | | |
| 8 | | | | | / / | | | / / | | | 8 |
| 9 | | | | | / / | | | / / | | | 9 |
| 10 | TOTALS (lines 7, 8 and 9) | | | | | $ 20,950,000 | $ 20,950,000 | | | $ 880,335 | 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.

**Facility Name:** LACEY CREEK **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

## XI. BALANCE SHEET - Unrestricted Operating Fund.

**As of** 12/31/2017 **(last day of reporting year)**

| | | 1 Operating | 2 After Consolidation* | |
|---|---|---|---|---|
| | **A. Current Assets** | | | |
| 1 | Cash on Hand and in Banks | $ 108,491 | $ | 1 |
| 2 | Cash-Patient Deposits | | | 2 |
| 3 | Accounts & Short-Term Notes Receivable-Patients (less allowance (24,752) ) | 986,170 | | 3 |
| 4 | Supply Inventory (priced at ) | | | 4 |
| 5 | Short-Term Investments | | | 5 |
| 6 | Prepaid Insurance | 18,571 | | 6 |
| 7 | Other Prepaid Expenses | 2,735 | | 7 |
| 8 | Accounts Receivable (owners or related parties) | | | 8 |
| 9 | Other(specify): See Page 7 Attachment | 23,847 | | 9 |
| 10 | **TOTAL Current Assets (sum of lines 1 thru 9)** | $ 1,139,815 | $ | 10 |
| | **B. Long-Term Assets** | | | |
| 11 | Long-Term Notes Receivable | | | 11 |
| 12 | Long-Term Investments | | | 12 |
| 13 | Land | 2,168,346 | | 13 |
| 14 | Buildings, at Historical Cost | 19,756,540 | | 14 |
| 15 | Leasehold Improvements, at Historical Cost | 1,748,622 | | 15 |
| 16 | Equipment, at Historical Cost | 1,235,874 | | 16 |
| 17 | Accumulated Depreciation (book methods) | (725,721) | | 17 |
| 18 | Deferred Charges | | | 18 |
| 19 | Organization & Pre-Operating Costs | 73,913 | | 19 |
| 20 | Accumulated Amortization - Organization & Pre-Operating Costs | (7,391) | | 20 |
| 21 | Restricted Funds | 911,602 | | 21 |
| 22 | Other Long-Term Assets (specify): | | | 22 |
| 23 | Other(specify): | (43) | | 23 |
| 24 | **TOTAL Long-Term Assets (sum of lines 11 thru 23)** | $ 25,161,742 | $ | 24 |
| 25 | **TOTAL ASSETS (sum of lines 10 and 24)** | $ 26,301,557 | $ | 25 |

| | | 1 Operating | 2 After Consolidation* | |
|---|---|---|---|---|
| | **C. Current Liabilities** | | | |
| 26 | Accounts Payable | $ 48,565 | $ | 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 | 185,084 | | 31 |
| 32 | Accrued Interest Payable | 103,607 | | 32 |
| 33 | Deferred Compensation | | | 33 |
| 34 | Federal and State Income Taxes | | | 34 |
| | **Other Current Liabilities(specify):** | | | |
| 35 | See Page 7 Attachment | 1,712,582 | | 35 |
| 36 | | | | 36 |
| 37 | **TOTAL Current Liabilities (sum of lines 26 thru 36)** | $ 2,049,839 | $ | 37 |
| | **D. Long-Term Liabilities** | | | |
| 38 | Long-Term Notes Payable | 242,852 | | 38 |
| 39 | Mortgage Payable | 20,391,998 | | 39 |
| 40 | Bonds Payable | | | 40 |
| 41 | Deferred Compensation | | | 41 |
| | **Other Long-Term Liabilities(specify):** | | | |
| 42 | FMV of Deriative | 1,573,700 | | 42 |
| 43 | | | | 43 |
| 44 | **TOTAL Long-Term Liabilities (sum of lines 38 thru 43)** | $ 22,208,550 | $ | 44 |
| 45 | **TOTAL LIABILITIES (sum of lines 37 and 44)** | $ 24,258,389 | $ | 45 |
| 46 | **TOTAL EQUITY** | $ 2,043,168 | $ | 46 |
| 47 | **TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)** | $ 26,301,557 | $ | 47 |

***(See instructions.)**

**Facility Name: LACEY CREEK** **Report Period Beginning: 01/01/2017 Ending: 12/31/2017**

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

| | I. Revenue | 1 Amount | |
|---|---|---|---|
| | **A. SLF Resident Care** | | |
| 1 | Gross SLF Resident Revenue | $ 3,979,205 | 1 |
| 2 | Discounts and Allowances | (4,666) | 2 |
| 3 | **SUBTOTAL Resident Care (line 1 minus line 2)** | $ 3,974,539 | 3 |
| | **B. Other Operating Revenue** | | |
| 4 | Special Services | 68,696 | 4 |
| 5 | Other Health Care Services | | 5 |
| 6 | Special Grants | | 6 |
| 7 | Gift and Coffee Shop | | 7 |
| 8 | Barber and Beauty Care | 9,480 | 8 |
| 9 | Non-Resident Meals | 1,848 | 9 |
| 10 | Laundry | | 10 |
| 11 | **SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)** | $ 80,024 | 11 |
| | **C. Non-Operating Revenue** | | |
| 12 | Contributions | | 12 |
| 13 | Interest and Other Investment Income | 2,874 | 13 |
| 14 | **SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)** | $ 2,874 | 14 |
| | **D. Other Revenue (specify):** | | |
| 15 | **See Page 8 Attachment** | 3,760 | 15 |
| 16 | | | 16 |
| 17 | **SUBTOTAL Other Revenue (sum of lines 15 and 16)** | $ 3,760 | 17 |
| 18 | **TOTAL REVENUE (sum of lines 3, 11, 14 and 17)** | $ 4,061,197 | 18 |

| | II. Expenses | 2 Amount | |
|---|---|---|---|
| | **A. Operating Expenses** | | |
| 19 | General Services | 833,941 | 19 |
| 20 | Health Care/ Personal Care | 572,229 | 20 |
| 21 | General Administration | 1,029,193 | 21 |
| | **B. Capital Expense** | | |
| 22 | Ownership | 1,747,208 | 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)** | $ 4,182,571 | 28 |
| 29 | **Income Before Income Taxes (line 18 minus line 28)** | $ (121,374) | 29 |
| 30 | **Income Taxes** | $ | 30 |
| 31 | **NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)** | $ (121,374) | 31 |
| | **III. Net Resident Care Revenue detailed by Payer Source** | | |
| 32 | Medicaid - Net Inpatient Revenue | $ 1,711,745 | 32 |
| 33 | Private Pay - Net Inpatient Revenue | 2,262,794 | 33 |
| 34 | Medicare - Net Inpatient Revenue | | 34 |
| 35 | Other-(specify) | | 35 |
| 36 | Other-(specify) | | 36 |
| 37 | TOTAL (This total must agree to Line 3) | $ 3,974,539 | 37 |

# Expenses PG 3 Other

| | General Services Other | |
|---|---|---|
| 5200-5000-0-0 | Operating Allocation | - |
| 5200-5124-0-0 | Exterminating | 2,542 |
| 5200-5127-0-0 | Rubbish Removal | 6,261 |
| 5200-5130-0-0 | Vehicle Expense | 424 |
| 5200-5131-0-0 | Transportation Service | - |
| 5300-5140-0-0 | Security & Monitoring | 2,312 |
| | | 11,538 |

| | Health Care & Programs | |
|---|---|---|
| | | - |

| | General Administration Other | Amt |
|---|---|---|
| 5160-5060-0-0 | Consulting | 3,305 |
| 5160-5063-0-0 | Legal | 17,592 |
| 5160-5064-0-0 | Accounting | 1,418 |
| 5160-5066-0-0 | Audit | 13,252 |
| 5160-5067-0-0 | Contract Labor-Serv Prov | - |
| 5160-5068-0-0 | Contract Labor | 49,692 |
| 5180-5079-0-0 | Bad Debt - Resident | 17,136 |
| 5180-5079-1-0 | Bad Debt - Resident - Recovery | - |
| 5180-5080-0-0 | Bad Debt - Resident Prior Period | - |
| 5180-5081-0-0 | Bad Debt - Medicaid Pending Denial | 9,275 |
| 5180-5081-1-0 | Bad Debt - Medicaid Pending - Recovery | - |
| 5180-5082-0-0 | Bad Debt - Medicaid Denial Prior Period | - |
| 5180-5083-0-0 | Bad Debt - Medicaid MCO | - |
| 5190-5000-0-0 | Other Admin Allocation | - |
| | | 111,670 |

| | Ownership Other | Amt |
|---|---|---|
| 9100-9101-0-0 | Interest & Dividend Income | - |
| 9100-9102-0-0 | Assessment Income | - |
| 9100-9103-0-0 | Assessment Expense | - |
| 9200-9201-1-0 | Amortization - Loan Fees | 37,151 |
| 9200-9202-0-0 | Financing Fees | - |
| 9200-9203-1-0 | Mortgage Interest Premium | - |
| 9200-9204-0-0 | Mortgage Service Fee | - |
| 9200-9205-0-0 | Mortgage Insurance Prem | - |
| 9200-9206-0-0 | Participation Fee | - |
| 9200-9207-0-0 | Letter of Credit Fee | - |
| 9200-9208-0-0 | Bond & Draw Fee | - |
| 9200-9209-0-0 | Remarketing and Trustee Fee | 3,000 |
| 9200-9210-0-0 | Interest Expense-Note | - |
| 9200-9211-0-0 | Interest Expense-LP | - |
| 9200-9212-0-0 | Debt Write-Off | - |
| 9300-9301-0-0 | Partnership Management Fee | - |
| 9300-9302-0-0 | Asset Management Fee | 12,500 |
| 9300-9303-0-0 | Incentive Management | - |
| 9300-9303-1-0 | Incentive Asset Mgmt Fee | - |
| 9300-9304-0-0 | Tax Credit Fees & Incentive Fee | - |
| 9300-9305-0-0 | Organizational Expense | - |
| 9300-9306-0-0 | Developer Fees | - |
| 9300-9307-0-0 | Closing Costs | - |
| 9700-9702-0-0 | Amortization Expense | 7,391 |
| 9900-9901-0-0 | Prior Period Adjustments | - |
| 9900-9902-0-0 | Dissolution of Business | - |
| 9900-9903-0-0 | Loss (Gain) on Sale of Assets | - |
| 9900-9904-0-0 | Business Interruption | - |
| 9900-9905-0-0 | Settlement | - |
| 9900-9906-0-0 | Property Damage Loss | - |
| 9900-9907-0-0 | Abandonment Loss | - |
| 9900-9908-0-0 | Grant Income | - |
| 9900-9909-0-0 | Misc: Title, Recording, Transfe | - |
| | | 60,042 |

# Balance Sheet PG 7 Other

Balance Sheet PG 7 Other, See Attachment

Balance Sheet

| | Other Current Assets Detail | Amt |
|---|---|---|
| 1102-9971-0-0 | A/R-Employee Advance | - |
| 1102-9972-0-0 | A/R-Gardant Mgmt Solutions | - |
| 1102-9973-0-0 | A/R-Insurance Reimbursemen | - |
| 1102-9974-0-0 | A/R-Subscription Receivable | - |
| 1102-9975-0-0 | A/R-CIP | - |
| 1102-9976-0-0 | A/R-Other | 17,807 |
| 1102-9978-0-0 | A/R-TIF/Abatement | - |
| 1105-0006-0-0 | Security Deposit-Equip & Util | 6,040 |
| 1105-0009-0-0 | Transfer Account | - |
| 1105-0012-0-0 | Undeposited Funds | - |
| | | 23,847 |

| | Other Long Term Assets Detail | |
|---|---|---|
| 1201-0020-0-0 | CIP | (43) |
| 1201-0021-0-0 | CIP- Land Option Addition | - |
| 1201-0022-0-0 | CIP- Other Addition | - |
| | | (43.20) |

| | Current Liabilities Detail | Amt |
|---|---|---|
| 2111-0040-0-0 | Construction Account Payable | - |
| 2112-0100-0-0 | Accrued Asset Management Fee | 14,584 |
| 2112-0101-0-0 | Accrued Partnership Mgmt Fee | - |
| 2112-0102-0-0 | Accrued Incentive Mgmt Fee | - |
| 2112-0102-1-0 | Accrued Incentive Asset Mgmt Fee | - |
| 2112-0105-0-0 | Accrued Liabilities | 64,713 |
| 2112-0110-0-0 | Accrued Insurance | - |
| 2112-0115-0-0 | Accrued Developer Fee | 1,575,000 |
| 2112-0130-0-0 | Accrued MIP | - |
| 2112-0140-0-0 | Accrued Vacation | - |
| 2112-0144-0-0 | Payroll Union Dues | - |
| 2112-0146-0-0 | Payroll Benefits | - |
| 2112-0150-0-0 | Security Deposits | - |
| 2112-0154-0-0 | Unclaimed Property | - |
| 2112-0155-0-0 | Reservation Deposit | 2,600 |
| 2112-0156-0-0 | Buy Down Credit | - |
| 2112-0157-0-0 | Unapplied Last Month Rent | - |
| 2112-0158-0-0 | Deferred Gain on Sale | - |
| 2112-0159-0-0 | Unearned Revenue | 55,685 |
| 2112-0159-1-0 | Medicaid Prepayments | - |
| 2112-0159-2-0 | Prepaid Medicaid Clearing | - |
| 2112-0159-3-0 | Prepaid Rent | - |
| | | 1,712,582 |

# Income Statement PG 8 Other

Income Statement PG 8 Other, See Attachment

Income Statement

| | Other Revenue | Amt |
|---|---|---|
| 3300-3388-0-0 | Contract Service-Serv Prov | - |
| 3300-3390-0-0 | Other | 3,760 |
| 3300-3391-0-0 | Property Tax Adjustments | - |
| 3300-3392-0-0 | Property Lease Income | - |
| 3300-3393-0-0 | Insurance Adjustments | - |
| 3300-3395-0-0 | Developer Fee Income | - |
| 3300-3396-0-0 | Home Office Rent Income | - |
| | | 3,760 |