

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2020  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2020)**

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.

<p><b>I. Facility ID Number:</b> <u>100X021</u></p> <p><b>Facility Name:</b> <u>Asbury Court Memory Care</u></p> <hr/> <p><b>Address:</b> <u>1750 S Elmhurst Road</u> <u>Des Plaines</u> <u>60018</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> ( <u>847</u> ) <u>228-1500</u> Fax # ( <u>847</u> ) <u>228-1579</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>2/28/2003</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>Michael Zahtz</u> <b>Telephone Number:</b> ( <u>847</u> ) <u>676-1700</u></p> <p><b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input checked="" type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other _____	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Michael Zahtz</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO</u></td> <td></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) ( <u>    </u> ) _____</td> <td>Fax # ( <u>    </u> ) _____</td> </tr> </table> <p align="right">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</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>Michael Zahtz</u>			(Title) <u>CFO</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) ( <u>    </u> ) _____	Fax # ( <u>    </u> ) _____
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Facility Name Asbury Court Memory Care

Report Period Beginning: 1/1/2020 Ending: 12/31/2020

**III. STATISTICAL DATA**

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

Date of change in certified units 9/1/2020

	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		Single Unit Apartment	28	3,416	1
2		Double Unit Apartment	12	1,464	2
3		Other		844	3
4		TOTALS	40	5,724	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	1,146	654		1,800	5
6	Double Unit	1,053	561		1,614	6
7	Other					7
8	TOTALS	2,199	1,215		3,414	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 59.64%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 402 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)

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**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

\* 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 principal? \_\_\_\_\_  
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 principal? \_\_\_\_\_  
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 principal? \_\_\_\_\_  
If no, explain. \_\_\_\_\_

Facility Name: Asbury Court Memory Care

Report Period Beginning:

1/1/2020

Ending: 12/31/2020

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	23,943	5,096	26,302	55,341		55,341	1
2	Housekeeping, Laundry and Maintenance	19,958	6,337	13,381	39,676		39,676	2
3	Heat and Other Utilities			15,675	15,675		15,675	3
4	Other (specify):			1,459	1,459		1,459	4
5	<b>TOTAL General Services</b>	<b>43,901</b>	<b>11,433</b>	<b>56,817</b>	<b>112,151</b>		<b>112,151</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	42,892	2,466	2,406	47,764		47,764	6
7	Activities and Social Services	7,155	857		8,012		8,012	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>50,047</b>	<b>3,323</b>	<b>2,406</b>	<b>55,776</b>		<b>55,776</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	11,236	2,929	64,411	78,576	(5,886)	72,690	10
11	Marketing Materials, Promotions and Advertising	6,499	556	8,928	15,983		15,983	11
12	Employee Benefits and Payroll Taxes	4,813			4,813		4,813	12
13	Insurance-Property, Liability and Malpractice	12,959			12,959	1,237	14,196	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>35,507</b>	<b>3,485</b>	<b>73,339</b>	<b>112,331</b>	<b>(4,649)</b>	<b>107,682</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>129,455</b>	<b>18,241</b>	<b>132,562</b>	<b>280,258</b>	<b>(4,649)</b>	<b>275,609</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			7,868	7,868	35,252	43,120	17
18	Interest					36,718	36,718	18
19	Real Estate Taxes					32,393	32,393	19
20	Rent -- Facility and Grounds			99,205	99,205	(99,205)		20
21	Rent -- Equipment			427	427		427	21
22	Other (specify): Mortgage insurance					5,693	5,693	22
23	<b>TOTAL Ownership</b>			<b>107,500</b>	<b>107,500</b>	<b>10,851</b>	<b>118,351</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>129,455</b>	<b>18,241</b>	<b>240,062</b>	<b>387,758</b>	<b>6,202</b>	<b>393,960</b>	<b>24</b>

Facility Name: Asbury Court Memory Care

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses	4	30.56	2
3	Certified Nurse Assistants	10	16.74	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	1	12.00	10
11	Laundry			11
12	Managers	1	45.05	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>16</b>	<b>\$</b>	<b>17</b>

**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
<b>Total</b>				<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$</b>
		<b>3</b>

**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	City
Asbury Gardens	North Aurora
Asbury Gardens Nursing and Rehab	North Aurora
Asbury of Kankakee Supportive Living	Kankakee
Asbury Court Nursing & Rehabilitation	Des Plaines

**OTHER RELATED BUSINESS ENTITIES**

Name	City	Type of Business
Des Plaines Property LLC	Des Plaines	Property
Asbury Healthcare	Lincolnwood	Management Co.

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).

Facility Name: Asbury Court Memory Care

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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
<b>Improvement Type</b>											
6	See Attachment2										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

Facility Name: Asbury Court Memory Care

Report Period Beginning: 1/1/2020

Ending: 2/31/2020

**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	<b>TOTAL</b>				\$			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		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		<b>A. Directly Facility Related</b>										
		<b>Long-Term</b>										
1						/ /	\$	\$	/ /		\$	1
2						/ /			/ /			2
3						/ /			/ /			3
		<b>Working Capital</b>										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		<b>TOTAL Facility Related</b>					\$	\$			\$	7
		<b>B. Non-Facility Related</b>										
8						/ /			/ /			8
9						/ /			/ /			9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$	\$			\$	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: Asbury Court Memory Care

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,155,400	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>238,752</u> )	1,100,808		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,679		6
7	Other Prepaid Expenses	11,430		7
8	Accounts Receivable (owners or related parties)	1,861,239		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,145,556	\$	10
	<b>B. Long-Term Assets</b>			
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	4,100,161		15
16	Equipment, at Historical Cost	690,187		16
17	Accumulated Depreciation (book methods)	(2,633,210)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,157,138	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,302,694	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 302,384	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,588		30
31	Accrued Taxes Payable	4,737		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes	70,000		34
	<b>Other Current Liabilities(specify):</b>			
35	Management Fee Payable	48,993		35
36	Entrance Fee Payable	40,546		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 553,248	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	510,400		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 510,400	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 1,063,648	\$	45
46	<b>TOTAL EQUITY</b>	\$ 5,239,046	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 6,302,694	\$	47

\*(See instructions.)

Facility Name: Asbury Court Memory Care

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

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

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 485,444	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 485,444</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services		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	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16	Miscellaneous Income		16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 485,444</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	112,151	19
20	Health Care/ Personal Care	55,776	20
21	General Administration	107,682	21
<b>B. Capital Expense</b>			
22	Ownership	118,351	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 393,960</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 91,484</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$ 55,295</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 36,189</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	210,894	32
33	Private Pay - Net Inpatient Revenue	274,550	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 485,444</b>	<b>37</b>

**Pg4 Related Party Expenses**

VII. C.

<u>Description</u>	<u>Amount</u>
Property Taxes	32,393.00
Insurance	1,237.00
Depreciation	35,252.00
Interest	36,718.00
Other Fees	5.00
Mortgage Insurance	5,693.00
Professional Fees	2,256.00
<b>Total Related Party Expenses</b>	<b><u>113,554</u></b>

**Pg3 Expenses Adjustments:**

Bad Debt	(8,147.00)	pg. 3 IV. 10
Professional Fees	2,261.00	pg. 3 IV. 10
Mortgage insurance	5,693.00	pg. 3 IV. 22
Property taxes	32,393.00	pg. 3 IV. 19
Insurance	1,237.00	pg. 3 IV. 13
Interest	36,718.00	pg. 3 IV. 18
Depreciation	35,252.00	pg. 3 IV. 17
Rent	(99,205.00)	pg. 3 IV. 20
<b>Total Adjustments</b>	<b><u>6,202</u></b>	



Entity	2014	2015	2016	2017	2018	2019	2020	2021	2022
Algeria	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Argentina	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Armenia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Australia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Austria	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Azerbaijan	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Bahrain	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Bangladesh	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Belarus	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Belgium	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Belize	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Benin	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Bhutan	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Bolivia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Bosnia and Herzegovina	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Brazil	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Bulgaria	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Burkina Faso	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Burundi	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Cambodia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Cameroon	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Canada	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Cape Verde	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Chad	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Chile	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
China	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Colombia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Costa Rica	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Cote d'Ivoire	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Croatia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Cuba	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Cyprus	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Czechia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Dominican Republic	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Dominica	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
DRC	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Ecuador	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Egypt	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
El Salvador	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Equatorial Guinea	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Eritrea	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Estonia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Ethiopia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Fiji	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Finland	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
France	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Ghana	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Guatemala	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Honduras	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Hungary	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
India	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Indonesia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Israel	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Italy	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Jamaica	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Japan	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Jordan	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Kazakhstan	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Kenya	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Korea	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Kuwait	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Kyrgyzstan	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Laos	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Latvia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Lebanon	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Lesotho	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Lithuania	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Luxembourg	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Macao	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Madagascar	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Mali	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Mexico	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Moldova	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Mongolia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Montenegro	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Morocco	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Mozambique	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Myanmar	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Nicaragua	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Niger	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Nigeria	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
North Macedonia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Oman	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Pakistan	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Panama	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Papua New Guinea	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Paraguay	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Peru	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Philippines	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Poland	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Portugal	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Romania	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Russia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Rwanda	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Saudi Arabia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Senegal	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Serbia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Singapore	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Slovakia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Slovenia	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
South Africa	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
South Korea	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Spain	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Sri Lanka	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Sweden	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Switzerland	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Taiwan	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Tanzania	1,000	1,000	1,000	1,					