

		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>I. Facility ID Number: <u>1000001</u></p> <p>Facility Name: <u>Evergreen Place Beardstown</u></p> <hr/> <p>Address: <u>8570 St Lukes Dr</u> <u>Beardstown</u> <u>62618</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Cass</u></p> <p>Telephone Number: (<u>217</u>) <u>323-1860</u> Fax # ()</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>1999</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" 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>IRS Exemption Code _____</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>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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	IRS Exemption Code _____	<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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</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 align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="2" style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>David M. Underwood</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>EVP & CFO</u></td> <td></td> </tr> </table> <table border="1" style="width:100%"> <tr> <td rowspan="4" style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) () _____ Fax # () _____</td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>David M. Underwood</u>			(Title) <u>EVP & CFO</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(Telephone) () _____ Fax # () _____																																									
<p>In the event there are further questions about this report, please contact:</p> <p>Name: <u>David M Underwood</u> Telephone Number: <u>309 823-7135</u></p> <p>Email Address: _____</p>																																										
<p>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>																																										

Facility Name Evergreen Place Beardstown

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 / /

	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	26	Single Unit Apartment	26	9,516	1
2		Double Unit Apartment			2
3		Other			3
4	26	TOTALS	26	9,516	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	1,126	3,221		4,347	5
6	Double Unit					6
7	Other					7
8	TOTALS	1,126	3,221		4,347	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 45.68%

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

None Also, indicate the number of unpaid bed-hold days the SLF had during this year. None (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: _____ Fiscal Year: _____

* 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: Evergreen Place Beardstown

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			
A. General Services								
1	Dietary and Food Purchase	42,640	37,650	1,652	81,942		81,942	1
2	Housekeeping, Laundry and Maintenance	36,641	28,749		65,390		65,390	2
3	Heat and Other Utilities			35,059	35,059		35,059	3
4	Other (specify):							4
5	TOTAL General Services	79,281	66,399	36,711	182,391		182,391	5
B. Health Care and Programs								
6	Health Care/ Personal Care	255,406	258		255,664		255,664	6
7	Activities and Social Services	9,725	3,268		12,993		12,993	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	265,131	3,526		268,657		268,657	9
C. General Administration								
10	Administrative and Clerical	65,429	25,189		90,618		90,618	10
11	Marketing Materials, Promotions and Advertising			3,407	3,407	(3,407)		11
12	Employee Benefits and Payroll Taxes			85,187	85,187		85,187	12
13	Insurance-Property, Liability and Malpractice			8,508	8,508		8,508	13
14	Other (specify):							14
15	TOTAL General Administration	65,429	25,189	97,102	187,720	(3,407)	184,313	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	409,841	95,114	133,813	638,768	(3,407)	635,361	16
Capital Expenses								
D. Ownership								
17	Depreciation			37,033	37,033		37,033	17
18	Interest			13,515	13,515		13,515	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			114,192	114,192		114,192	20
21	Rent -- Equipment			5,260	5,260		5,260	21
22	Other (specify):							22
23	TOTAL Ownership			170,000	170,000		170,000	23
24	GRAND TOTAL (Sum of lines 16 and 23)	409,841	95,114	303,813	808,768	(3,407)	805,361	24

Facility Name: Evergreen Place Beardstown

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	0.70	\$ 26.10	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6.54	15.90	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			10
11	Laundry			11
12	Managers	0.94	33.48	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	8.18	\$ 18.79	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	None			\$	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	1	City	2
Heritage Manor-Beardstown LLC		Beardstown	
Heritage Manor RE-Beardstown LLC			

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).

Facility Name: Evergreen Place Beardstown

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	26				\$	\$ 34,701		\$ 34,701	\$	\$	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Replace compressor		2012	14,538						6
7		Elevator door restrictor		2013	6,300						7
8		Duct heater replacement		2013	3,341						8
9		Replace dishwasher		2014	5,478						9
10		Rebuild fan motor		2014	3,608						10
11		Chiller replacement		2014	150,950						11
12		Duct heater replacement		2015	6,295						12
13		Window replacements		2015	53,001						13
14		Replaced electric water heater		2017	9,174						14
15		Replaced motherboard - chiller		2018	2,795						15
16		Installed infared protection system		2018	3,068						16
17		TOTAL (lines 1 thru 16)			\$ 258,548	\$ 34,701		\$ 34,701	\$	\$	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	\$ 29,699	\$ 2,332	\$ 2,332	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 29,699	\$ 2,332	\$ 2,332	\$		\$	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 & ID Number Evergreen Place Beardstown

#

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 5, Carried Forward		\$ 258,548	\$ 34,701		\$ 34,701	\$	\$	1
2									2
3	No Improvements in 2019	2019							3
4									4
5	Replace duct heater	2020	3,895						5
6	Replace entry door	2020	10,375						6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 272,818	\$ 34,701		\$ 34,701	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name: Evergreen Place Beardstown

Report Period Beginning: 1/1/2020

Ending: 2/31/2020

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Heritage Manor Real Estate LLC

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			/ /	\$ 114,192			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				\$ 114,192			7

8. Is movable equipment rental included in building rental? YES NO

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	Busey Bank		XX	Working Capital	/ /			/ /		13,515
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$	\$			\$ 13,515
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$	\$			\$ 13,515

* 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: Evergreen Place Beardstown

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,826	\$	1
2	Cash-Patient Deposits	15,127		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	136,028		3
4	Supply Inventory (priced <u>FIFO</u>)	26,373		4
5	Short-Term Investments			5
6	Prepaid Insurance	753		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,092,781)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (912,674)	\$	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			16
17	Accumulated Depreciation (book methods)			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
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (912,674)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,127		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	192,723		30
31	Accrued Taxes Payable	1,219		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Bed Tax</u>	8,640		35
36	<u>Deferred Stimulus</u>	167,505		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 385,214	\$	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)	\$ 385,214	\$	45
46	TOTAL EQUITY	\$ (1,297,888)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ (912,674)	\$	47

*(See instructions.)

Facility Name: Evergreen Place Beardstown

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	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 902,730	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 902,730	3
B. Other Operating Revenue			
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	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	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	Miscellaneous		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)	\$ 902,730	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	182,391	19
20	Health Care/ Personal Care	268,657	20
21	General Administration	187,720	21
B. Capital Expense			
22	Ownership	170,000	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)	\$ 808,768	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 93,962	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 93,962	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$	32
33	Private Pay - Net Inpatient Revenue		33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$	37

Account Number

Description

GL Code

Unit

Quantity

Rate

Amount

Account Number

Description

GL Code

Unit

Quantity

Rate

Amount

Account Number

Description

GL Code

Unit

Quantity

Rate

Amount

Heritage Health Beardstown and Evergreen Place SLF
Allocation of Shared Expenses
For the Twelve Months Ending December 31, 2020

	SLF 12/31/20	SNF 12/31/20		SLF %
PRIVATE DAYS	3,221	5,365		
MEDICAID DAYS	1,126	14,878		
MEDICARE DAYS	0	1,475		
TOTAL DAYS	4,347	21,718	26,065	16.68%
LICENSED DAYS	9,516	28,914	38,430	
PERCENT OCCUPANCY	45.68%	75.11%	67.82%	

	<u>Per G/L</u>
ROUTINE SERVICE INCOME	902,730
NET ANCILLARY INCOME	0
TOTAL OPERATING INCOME	<u>902,730</u>

SUMMARY:	<u>ALLOCATED</u>	<u>DIRECT</u>	<u>TOTAL</u>
GENERAL AND ADMIN	93,694	94,025	187,719
PROPERTY AND PLANT	53,626	23,076	76,702
DIETARY	79,297	2,646	81,943
LAUNDRY	28,965	0	28,965
HOUSEKEEPING	0	42	42
NURSING	0	255,664	255,664
OTHER SERVICES	9,725	3,268	12,993
TOTAL EXPENSES	<u>265,307</u>	<u>378,721</u>	<u>644,028</u>

GROSS MARGIN 258,702

ALLOCATED INTEREST	12,748
RENT - DIRECT CHARGE	114,192
ALLOCATED DEPRECIATION	37,033
ALLOCATED LOAN FEE AMORTIZATION	767
FINANCING & MGMT	<u>164,741</u>

NET INCOME 93,961

Shared Expense Allocation

	<u>Per G/L</u>	<u>Allocation</u>
<u>G&A</u>		
PR Taxes	206,252	34,398
Benefits	81,873	13,654
Health ins	203,913	34,008
Liab ins	51,012	8,508
Work Comp	18,750	3,127
	<u>561,800</u>	<u>93,694</u>

<u>Maint</u>		
Wages	79,788	13,307
Utilities	210,217	35,059
Leased Equip	31,542	5,260
	<u>321,547</u>	<u>53,626</u>

<u>Dietary</u>		
Wages	255,673	42,640
Food	222,108	37,042
Meal Fee	(2,312)	(386)
	<u>475,469</u>	<u>79,297</u>

<u>Laundry/Hsk</u>		
Wages	139,913	23,334
Supplies	33,761	5,631
	<u>173,674</u>	<u>28,965</u>

<u>Activities</u>		
Wages	58,313	9,725

Total Alloc 1,590,803 265,307

SLF Direct Costs

	<u>Per G/L</u>
<u>G&A</u>	
Wages	65,429
PR/Mkt	3,407
Supplies	5,768
All Other	19,421
Taxes	0
	<u>94,025</u>

<u>Maint</u>	
Repairs	23,076
	<u>23,076</u>

<u>Dietary</u>	
Consult	1,652
Supplies	994
	<u>2,646</u>

<u>Laundry</u>	
Salary	0
Supplies	0
	<u>0</u>

<u>Housekeeping</u>	
Salary	0
Supplies	42
	<u>42</u>

<u>Nursing</u>	
Salaries	255,406
Supplies	258
	<u>255,664</u>

<u>Other Svcs</u>	
Supplies	3,268

Direct Cost 378,721

Total 644,028