

		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.

I. Facility ID Number: 1000080

Facility Name: Foxes Grove Supp Living Comm

Address: 395 Edwardsville Rd Wood River 62095
 Number City Zip Code

County: Madison

Telephone Number: (618) 259 - 0851 Fax # (618) 259 - 0854

Federal Employer ID Number: _____

Date Current Owners were Certified: 2/1/2020

Type of Ownership:

<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 _____	

In the event there are further questions about this report, please contact:
Name: David Trimble **Telephone Number:** (813) 675 - 2318
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 2/1/2020 to 12/31/2020 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) <u>David Trimble</u>	
	(Title) <u>Vice President, Reimbursement</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>()</u> Fax # <u>()</u>	

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 Foxes Grove Supp Living Comm

Report Period Beginning: 2/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

Date of change in certified units 2/1/2020

	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	83	Single Unit Apartment	83	27,805	1
2	11	Double Unit Apartment	11	3,685	2
3		Other			3
4	94	TOTALS	94	31,490	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	16,535	6,223		22,758	5
6	Double Unit	649	2,289		2,938	6
7	Other					7
8	TOTALS	17,184	8,512		25,696	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 81.60%

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

N/A Also, indicate the number of unpaid bed-hold days the SLF had during this year. N/A (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 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? N/A
If no, explain. N/A

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? N/A
If no, explain. N/A

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? N/A
If no, explain. N/A

Facility Name: Foxes Grove Supp Living Comm

Report Period Beginning:

2/1/2020

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	124,598	155,320	89,852	369,770	1,620	371,390	1
2	Housekeeping, Laundry and Maintenance	104,727	28,172	64,872	197,771	7,257	205,028	2
3	Heat and Other Utilities			112,761	112,761	(3,071)	109,690	3
4	Other (specify): Infectious Waste Disposal			2,193	2,193		2,193	4
5	TOTAL General Services	229,325	183,492	269,678	682,495	5,807	688,302	5
B. Health Care and Programs								
6	Health Care/ Personal Care	526,662	193,108	20,587	740,357	34,107	774,464	6
7	Activities and Social Services	42,020	1,604	4,003	47,627		47,627	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	568,682	194,712	24,590	787,984	34,107	822,091	9
C. General Administration								
10	Administrative and Clerical	211,647	14,445	286,194	512,286	(17,061)	495,225	10
11	Marketing Materials, Promotions and Advertising			6,514	6,514	(1,357)	5,157	11
12	Employee Benefits and Payroll Taxes	118,327			118,327		118,327	12
13	Insurance-Property, Liability and Malpractice			116,950	116,950		116,950	13
14	Other (specify):							14
15	TOTAL General Administration	329,974	14,445	409,658	754,077	(18,418)	735,659	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,127,981	392,649	703,926	2,224,556	21,496	2,246,052	16
Capital Expenses								
D. Ownership								
17	Depreciation			3,840	3,840	53,362	57,202	17
18	Interest			95,520	95,520	132,513	228,033	18
19	Real Estate Taxes			71,995	71,995	(1,735)	70,260	19
20	Rent -- Facility and Grounds			149,183	149,183	(149,183)		20
21	Rent -- Equipment			11,826	11,826		11,826	21
22	Other (specify): Amort Exp - Other Intangibles			226	226	4,634	4,860	22
23	TOTAL Ownership			332,590	332,590	39,591	372,181	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,127,981	392,649	1,036,516	2,557,146	61,087	2,618,233	24

Facility Name: Foxes Grove Supp Living Comm
 Report Period Beginning: 2/1/2020
 Ending: 12/31/2020

	Adjustments	Amount	Sch V Line Ref
1	Non- Allowable Expenses:		1
2	Promotional Advertising	(1,357)	11 2
3	Cable Television	(3,071)	3 3
4	Bad Debt	(53,731)	10 4
5	Finance Chgs Late Fees	(217)	10 5
6	Amortization of Operating Rights	(226)	22 6
7	Misc Rev Meals	(421)	1 7
8	Misc Rev Vending	(143)	1 8
9	Misc Rev Interest	(4)	18 9
10	Misc Rev Other	(420)	10 10
11	Interest Income	(894)	18 11
12	Bistro Income	(5)	1 12
13	Adjust Real Estate Tax to Actual	(1,735)	19 13
14			14
15	Home Office Costs - Greystone Healthcare Management Corp. :		15
16	Management Fee	(134,326)	10 16
17	Home Office Costs - Admin	120,143	10 17
18	Home Office Costs - Nursing	32,835	6 18
19	Home Office Costs - Dietary	1,446	1 19
20	Home Office Costs - Property	4,860	22 20
21			21
22	Related Party Property Costs - 395 East Edwardsville Road LLC :		22
23	Rent	(149,183)	20 23
24	Interest	133,411	18 24
25	Depreciation/Amortization	53,362	17 25
26	Other Administrative Expense	36,942	10 26
27	Expense Equip - Dietary	743	1 27
28	Expense Equip - Maintenance	7,257	2 28
29	Expense Equip - Nursing	1,272	6 29
30	Expense Equip - Admin	14,548	10 30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49			49
50			50
	Total	61,087	

Facility Name: Foxes Grove Supp Living Comm

Report Period Beginning: 2/1/2020

Ending: 12/31/2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.07	\$ 27.58	1
2	Licensed Practical Nurses	5.11	23.22	2
3	Certified Nurse Assistants	9.06	14.06	3
4	Activity Director & Assistants	1.63	13.31	4
5	Social Service Workers	0.02	17.26	5
6	Head Cook	-		6
7	Cook Helpers/Assistants	5.37	12.12	7
8	Dishwashers	-		8
9	Maintenance Workers	1.57	12.24	9
10	Housekeepers	3.41	10.41	10
11	Laundry	-		11
12	Managers	1.00	35.01	12
13	Other Administrative	1.07	15.78	13
14	Clerical	3.24	13.81	14
15	Marketing	0.49	28.84	15
16	Other	-		16
17	Total (lines 1 thru 16)	33.04	\$ 13.98	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	1	City	2
See Attachments1		See Attachments1	

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: Greystone Healthcare Management Corp If yes, what is the value of those services? \$ 159,284

(Please attach a separate schedule itemizing those services.) See AttPG3A (line 15-20)

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) See AttPG3A (line 22 - 30)

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 Type of Entity	3
Edwardsville NH LLC		Edwardsville,IL	Skilled Nursing Facility	
Rockford NH LLC		Rockford,IL	Skilled Nursing Facility	
Moline NH LLC		Moline,IL	Skilled Nursing Facility	
St. Charles NH LLC		St. Charles,IL	Skilled Nursing Facility	
Elgin NH LLC		Elgin,IL	Skilled Nursing Facility	
Inverness NH LLC		Inverness,IL	Skilled Nursing Facility	
Northbrook NH LLC		Northbrook,IL	Skilled Nursing Facility	
Joliet NH LLC		Joliet,IL	Skilled Nursing Facility	
East Peoria NH LLC		East Peoria,IL	Skilled Nursing Facility	
Alton NH LLC		Alton,IL	Skilled Nursing Facility	
Peoria NH LLC		Peoria,IL	Skilled Nursing Facility	
St. Louis NH LLC		St. Louis,MO	Skilled Nursing Facility	
Alhambra NH, L.L.C.		Saint Petersburg,FL	Skilled Nursing Facility	
Greenbrook NH, L.L.C.		Saint Petersburg,FL	Skilled Nursing Facility	
LP Orlando LLC		Apopka,FL	Skilled Nursing Facility	
Carlton Shores NH LLC		Daytona Beach,FL	Skilled Nursing Facility	
Greenbriar NH, L.L.C.		Bradeenton,FL	Skilled Nursing Facility	
Isle Health NH LLC		Orange Park,FL	Skilled Nursing Facility	
La Mer LLC		Miami,FL	Skilled Nursing Facility	
Lady Lake NH, L.L.C.		Lady Lake,FL	Skilled Nursing Facility	
Lehigh Acres NH LLC		Lehigh Acres,FL	Skilled Nursing Facility	
Colonial Care NH, L.L.C.		Saint Petersburg,FL	Skilled Nursing Facility	
Heritage NH, L.L.C.		North Miami Beach,FL	Skilled Nursing Facility	
North Rehab NH, L.L.C.		Saint Petersburg,FL	Skilled Nursing Facility	
The Oaks NH, L.L.C.		Gainesville,FL	Skilled Nursing Facility	
Ridgecrest NH, L.L.C.		Deland,FL	Skilled Nursing Facility	
Riverwood Health NH LLC		Starke,FL	Skilled Nursing Facility	
Rockledge NH, L.L.C.		Rockledge,FL	Skilled Nursing Facility	
Venice NH, L.L.C.		Venice,FL	Skilled Nursing Facility	
Terrace Health NH LLC		Gainesville,FL	Skilled Nursing Facility	
Mulberry Grove NH LLC		The Villages,FL	Skilled Nursing Facility	
Gardens Health NH LLC		Daytona Beach,FL	Skilled Nursing Facility	
Citrus Hills NH LLC		Hernando,FL	Skilled Nursing Facility	
Innovative Medical Management Solutions LLC		Clermont,FL	Skilled Nursing Facility	
New Horizon NH, L.L.C.		Ocala,FL	Skilled Nursing Facility	
Ponce NH LLC		St. Augustine,FL	Skilled Nursing Facility	
Jackson Heights NH, L.L.C.		Miami,FL	Skilled Nursing Facility	
Viera NH LLC		Viera,FL	Skilled Nursing Facility	
Villa Health NH LLC		Deland,FL	Skilled Nursing Facility	
Village Place NH LLC		Port Charlotte,FL	Skilled Nursing Facility	
Palm Court NH, L.L.C.		Wilton Manors,FL	Skilled Nursing Facility	
Woodland Grove NH LLC		Jacksonville,FL	Skilled Nursing Facility	
Springs of Lady Lake ALF, L.L.C.		Lady Lake,FL	Assisted Living Facility	
Greystone Home Healthcare of Greater Orlando LLC		Orlando, FL	Home Health	
Greystone Home Healthcare of Greater Tampa Bay LLC		Sun City Center, FL	Home Health	
Greystone Home Health Care LLC		Clearwater, FL	Home Health	
Greystone Home Health Care LLC		The Villages, FL	Home Health	
Greystone Home Health Care LLC		Daytona Beach, FL	Home Health	
Solana Home Health Agency LLC		Sarasota, FL	Home Health	

Facility Name: Foxes Grove Supp Living Comm

Report Period Beginning:

2/1/2020

Ending:

12/31/2020

VIII. OWNERSHIP COSTS

A. Purchase price of land \$ 240,000 Year land was acquired 2020

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	94		2020	1987-1990	\$ 1,847,004	\$ 43,412	39	\$ 43,412	\$	\$ 43,412	1
2											2
3											3
4											4
5											5
Improvement Type											
6	1	Air Handler		2020	2,633	219	7	219		219	6
7	1	Nurse Call System Computer		2020	4,740	395	7	395		395	7
8	25	1 1/2 Ton Carrier Condensers		2020	40,847	973	7	973		973	8
9	2	2 Ton Condensers		2020	2,920	139	7	139		139	9
10		New Carpeting for Various Rooms		2020	20,600	229	15	229		229	10
11		Parking Lot Asphalt		2020	28,641	636	15	636		636	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 1,947,385	\$ 46,003		\$ 46,003	\$	\$ 46,003	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	\$ 49,409	\$ 7,358	\$ 7,358	\$	5 - 7	\$ 7,358	18
19	Vehicles	57,605	3,840	3,840		5	3,840	19
20	TOTAL (lines 18 and 19)		\$ 107,014	\$ 11,198	\$ 11,198		\$ 11,198	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: Foxes Grove Supp Living Comm

Report Period Beginning: 2/1/2020

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	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	Mizuho Capital Markets LLC		X	Mortgage	2/1/20	\$ 2,079,103	\$ 2,079,103	2/1/45	0.0700	\$ 133,411	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	Mizuho Capital Markets LLC		X	Line of Credit	2/1/20	1,470,179	1,470,179	2/1/25	0.0700	95,520	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 3,549,282	\$ 3,549,282			\$ 228,931	7
	B. Non-Facility Related										
8	Interest Income/Misc Rev Interest		X		/ /			/ /		(898)	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 3,549,282	\$ 3,549,282			\$ 228,033	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: **Foxes Grove Supp Living Comm**Report Period Beginning: **2/1/2020**

Ending:

12/31/2020**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2020

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 13,176	\$ 18,718	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>53,731</u>)	288,506	288,506	3
4	Supply Inventory (priced <u>cost</u>)	45,770	45,770	4
5	Short-Term Investments			5
6	Prepaid Insurance	22,372	22,372	6
7	Other Prepaid Expenses	4,719	4,719	7
8	Accounts Receivable (owners or related parties)	72,898	97,483	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 447,441	\$ 477,568	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		240,000	13
14	Buildings, at Historical Cost		1,847,004	14
15	Leasehold Improvements, at Historical Cost		49,241	15
16	Equipment, at Historical Cost	57,605	181,973	16
17	Accumulated Depreciation (book methods)	(3,840)	(59,918)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	13,854	28,349	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(226)	(2,880)	20
21	Restricted Funds		503,897	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP</u>		87,253	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 67,393	\$ 2,874,919	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 514,834	\$ 3,352,487	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 62,316	\$ 108,220	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,150	24,150	28
29	Short-Term Notes Payable	10,136	10,136	29
30	Accrued Salaries Payable	47,693	47,693	30
31	Accrued Taxes Payable	73,700	73,729	31
32	Accrued Interest Payable		12,215	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Accrued Expenses Other</u>	4,232	15,782	35
36	<u>Accounts Payable - Related Parties</u>	483,092	577,492	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 705,319	\$ 869,417	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	44,329	44,329	38
39	Mortgage Payable			39
40	Bonds Payable		2,079,103	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)	\$ 44,329	\$ 2,123,432	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 749,648	\$ 2,992,849	45
46	TOTAL EQUITY	\$ (234,814)	\$ 359,638	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 514,834	\$ 3,352,487	47

*(See instructions.)

Facility Name: Foxes Grove Supp Living Comm

Report Period Beginning: 2/1/2020

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	\$ 2,822,263	1
2	Discounts and Allowances	(137,483)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,684,780	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	569	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 569	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	898	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 898	14
D. Other Revenue (specify):			
15	Misc Rev Other	420	15
16	Grant Income	367,709	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 368,129	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,054,376	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	682,495	19
20	Health Care/ Personal Care	787,984	20
21	General Administration	754,077	21
B. Capital Expense			
22	Ownership	332,590	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)	\$ 2,557,146	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 497,230	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 497,230	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 1,925,376	32
33	Private Pay - Net Inpatient Revenue	759,404	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,684,780	37