

		FOR BHF USE			

LL2

Supportive Living Facility

2021

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2021)

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: 1000036

Facility Name: Grand Regency of South Shore

Address: 7419 South Exchange Chicago 60649

Number City Zip Code

County: Cook

Telephone Number: (773) 721-6600 Fax #

Federal Employer ID Number:

Date Current Owners were Certified: 5/19/2004

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 checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input 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: Steven N. Lavenda Telephone Number: (847) - 282- 6300

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 1/1/2021 to 12/31/2021 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)

(Title)

Paid
Preparer

(Signed) (Date)

*Subject to the attached Accountants' Consulting Report

(Print Name and Title) Steven N. Lavenda, CPA Partner

(Firm Name & Address) Marcum LLP Nine Parkway North, Suite 200 Deerfield, IL 60015

(Telephone) (847) 282-6300 Fax (847) 282-6301

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

III. STATISTICAL DATA

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

Date of change in certified units N/A

	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	129	Single Unit Apartment	129	47,085	1
2	10	Double Unit Apartment	10	3,650	2
3		Other			3
4	139	TOTALS	139	50,735	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	32,454	880		33,334	5
6	Double Unit					6
7	Other					7
8	TOTALS	32,454	880		33,334	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 65.70%

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)

None

H. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/21 Fiscal Year: 12/31/21

* 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. _____

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. _____

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. _____

STATE OF ILLINOIS

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Facility Name: Grand Regency of South Shore

Report Period Beginning:

1/1/2021

Ending:

12/31/2021

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	207,882	223,136	14,287	445,305		445,305	1
2	Housekeeping, Laundry and Maintenance	192,010	51,901	141,729	385,640	(32,919)	352,721	2
3	Heat and Other Utilities			129,728	129,728	1,352	131,080	3
4	Other (specify):							4
5	TOTAL General Services	399,892	275,037	285,744	960,673	(31,566)	929,107	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	465,004	9,922		474,926	10,405	485,331	6
7	Activities and Social Services	33,091	1,877	1,870	36,838		36,838	7
8	Other (specify):					252	252	8
9	TOTAL Health Care and Programs	498,095	11,799	1,870	511,764	10,657	522,421	9
	C. General Administration							
10	Administrative and Clerical	290,639	8,449	342,501	641,589	(157,466)	484,123	10
11	Marketing Materials, Promotions and Advertising	44,110		11,360	55,470	1,990	57,460	11
12	Employee Benefits and Payroll Taxes			173,701	173,701		173,701	12
13	Insurance-Property, Liability and Malpractice			44,334	44,334	73,522	117,856	13
14	Other (specify):					1,930	1,930	14
15	TOTAL General Administration	334,749	8,449	571,896	915,094	(80,025)	835,069	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,232,736	295,285	859,510	2,387,531	(100,934)	2,286,597	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			24,450	24,450	164,743	189,193	17
18	Interest					390,160	390,160	18
19	Real Estate Taxes			192,363	192,363		192,363	19
20	Rent -- Facility and Grounds			599,771	599,771	(591,123)	8,648	20
21	Rent -- Equipment			5,676	5,676		5,676	21
22	Other (specify):							22
23	TOTAL Ownership			822,260	822,260	(36,219)	786,041	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,232,736	295,285	1,681,770	3,209,791	(137,153)	3,072,638	24

STATE OF ILLINOIS		Page 3A
Grand Regency of South Shore		
Report Period Beginning:	1/1/2021	
Ending:	12/31/2021	
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1 Non-Straight Line Depreciation	20,614	17 1
2 Interest Income	(2,073)	18 2
3 Bank Charges	(5,523)	10 3
4 Cable Service	(8,901)	02 4
5 Use Tax	(156)	10 5
6 Meals & Entertainment	(50)	10 6
7 State of Illinois Income Tax	(67,800)	10 7
8 Additional R&M	1,708	02 8
9 Capitalized R&M	(46,582)	02 9
10		10
11 MANAGEMENT OFFICE ALLOCATION		11
12 Housekeeping/Maint/Laundry	353	02 12
13 Utilities	1,352	03 13
14 Health Care / Personal Care	10,405	06 14
15 Health Care Emp Ben/Payroll Taxes	252	08 15
16 Administrative & General	140,714	10 16
17 Advertising & Marketing	1,990	11 17
18 Insurance	13,909	13 18
19 Admin Emp Benefits & Payroll Taxes	1,930	14 19
20 Building Rental	8,648	20 20
21 Management Fees	(225,452)	10 21
22		22
23 BUILDING COMPANY		23
24 Rent	(599,771)	20 24
25 Interest Income	(293)	18 25
26 Asset Management Fee	20,512	02 26
27 Interest Expense	392,950	18 27
28 Depreciation	144,129	17 28
29 Insurance	59,612	13 29
30		30
31		31
32		32
33		33
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97		97
98		98
99		99
100		100
101 Total	(137,153)	101

Facility Name: Grand Regency of South Shore

Report Period Beginning 1/1/2021 Ending: 12/31/2021

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2.56	\$ 27.28	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	10.29	14.94	3
4	Activity Director & Assistants	1.00	15.85	4
5	Social Service Workers			5
6	Head Cook	1.00	18.25	6
7	Cook Helpers/Assistants	5.37	15.21	7
8	Dishwashers			8
9	Maintenance Workers	0.27	35.07	9
10	Housekeepers	5.46	15.16	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.02	40.54	13
14	Clerical	6.38	15.42	14
15	Marketing	0.64	33.18	15
16	Other			16
17	Total (lines 1 thru 16)	33.99	\$ 17.43	17

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
Rockford Supportive Living	Rockford, IL
Robbins Supportive Living	Robbins, IL
Jackson Park Supportive Living	Chicago, IL
Grand Regency of Peoria	Peoria, IL

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
Grand Lifestyles	Skokie, IL	Management Co.
Coles IL SLF Realty	Chicago, IL	Building Co.
Grand at Twin Lakes	Palatine, IL	Ind. Living

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: N/A 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).

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	N/A			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties Amount of Fee

1	N/A	\$	1
2			2
Total		\$	3

Facility Name: Grand Regency of South Shore

Report Period Beginning:

1/1/2021

Ending:

12/31/2021

VIII. OWNERSHIP COSTS

A. Purchase price of land 305,000 Year land was acquired 2016

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	139		2016	2004	\$ 2,458,747	\$ 144,129	35	\$ 70,250	\$ (73,879)	\$ 582,813	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Total From Supplemental Page 5's				292,648	24,450	20	14,633	(9,817)	44,308	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)				\$ 2,751,395	\$ 168,579		\$ 84,883	\$ (83,696)	\$ 627,121	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	\$ 1,024,066	\$	\$ 102,406	102,406		\$ 585,483	18
19	Vehicles	9,522		1,904	1,904		7,616	19
20	TOTAL (lines 18 and 19)	\$ 1,033,588	\$	\$ 104,310	104,310		\$ 593,099	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 Grand Regency of South Shore

#

Report Period Beginning:

1/1/2021

Ending:

12/31/2021

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Installed Scaled Protectors	2017	\$ 2,535	\$ 168,579	20	\$ 127	\$ (168,452)	\$ 634	1
2	Installed Door Restrictors On Elevators	2017	2,980		20	149	149	745	2
3	Installed Surveillance System	2017	3,755		20	188	188	939	3
4	1St-5Th Floor Corridor/Lounge-Paint/Lighting/Floor Base	2018	132,410		20	6,621	6,621	26,482	4
5	Power Events Work - Parts & Labor	2018	6,778		20	339	339	1,356	5
6	1St Floor Lighting/Sconces	2019	33,744		20	1,687	1,687	5,061	6
7	Repair And Installation Of New Flooring	2019	5,492		20	275	275	825	7
8	Installation Of Vinyl Flooring	2019	14,829		20	741	741	2,223	8
9	Repair Of Walk-In Freezer, Install New Pump	2020	5,633		20	282	282	564	9
10	Flooring	2020	12,800		20	640	640	1,280	10
11	Elevator Repair	2020	3,007		20	150	150	300	11
12	Elevator Repair	2020	3,185		20	159	159	318	12
13	Replaced Compressor	2020	2,906		20	145	145	290	13
14	Repair Exhaust Fan Motor In Kitchen	2020	3,212		20	161	161	322	14
15	New Oversized Gutter And Downspout	2021	22,750		20	1,138	1,138	1,138	15
16	Replaced Worn Elevator Valve	2021	11,400		20	570	570	570	16
17	Ptac	2021	2,979		20	149	149	149	17
18	Pull Stations & Call Buttons	2021	2,946		20	147	147	147	18
19	Replace Kitchen Fan	2021	4,500		20	225	225	225	19
20	Repair Walk-In Cooler	2021	4,592		20	230	230	230	20
21	Roof Repairs	2021	6,800		20	340	340	340	21
22	Repair Walk-In Freezer	2021	3,414		20	171	171	171	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)		\$ 292,648	\$ 168,579		\$ 14,633	\$ (153,946)	\$ 44,308	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1			\$	\$ 168,579		\$	\$ (168,579)	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$ 168,579		\$	\$ (168,579)	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name: Grand Regency of South Shore Report Period Beginning: 1/1/2021 Ending: 12/31/2021

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6	Allocated from Grand Lifestyle			/ /	8,648			6
7	TOTAL				\$ 8,648			7

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

9. Rental amount for movable equipment \$ 5,676

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	MB Financial		X	Mortgage	/ /	\$	6,746,324	/ /		\$ 392,950	1	
2					/ /			/ /			2	
3					/ /			/ /			3	
	Working Capital											
4					/ /			/ /			4	
5					/ /			/ /			5	
6					/ /			/ /			6	
7	TOTAL Facility Related					\$	6,746,324				\$ 392,950	7
	B. Non-Facility Related											
8	Interest Income		X		/ /			/ /		-2,497	8	
9	Interest Income - Bldg Co		X		/ /			/ /		-293	9	
10	TOTALS (lines 7, 8 and 9)					\$	6,746,324				\$ 390,160	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.

STATE OF ILLINOIS

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Facility Name: Grand Regency of South Shore

Report Period Beginning: 1/1/2021

Ending: 12/31/2021

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2021

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,438,264	\$ 1,514,135	1
2	Cash-Patient Deposits	6,585	6,585	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	942,550	1,048,883	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	133,592	133,592	6
7	Other Prepaid Expenses	151,979	259,079	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,672,970	\$ 2,962,274	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		305,000	13
14	Buildings, at Historical Cost		2,458,747	14
15	Leasehold Improvements, at Historical Cost	24,450	24,450	15
16	Equipment, at Historical Cost	299,995	1,196,248	16
17	Accumulated Depreciation (book methods)	(324,445)	(1,691,046)	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): See Attached	164,991	2,248,139	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 164,991	\$ 4,541,538	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,837,961	\$ 7,503,812	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 132,536	\$ 194,165	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	103,168	103,168	30
31	Accrued Taxes Payable	148,681	148,681	31
32	Accrued Interest Payable		22,094	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36	See Attached	26,062	26,062	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 410,447	\$ 494,170	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		6,746,324	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43	See Attached	340,191	340,191	43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 340,191	\$ 7,086,515	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 750,638	\$ 7,580,685	45
46	TOTAL EQUITY	\$ 2,087,323	\$ (76,873)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,837,961	\$ 7,503,812	47

*(See instructions.)

Facility Name: Grand Regency of South Shore

Report Period Beginning: 1/1/2021

Ending:

12/31/2021

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	\$ 4,447,872	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,447,872	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	2,497	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,497	14
	D. Other Revenue (specify):		
15	See Attached	71,359	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 71,359	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,521,728	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	960,673	19
20	Health Care/ Personal Care	511,764	20
21	General Administration	915,094	21
	B. Capital Expense		
22	Ownership	822,260	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)	\$ 3,209,791	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 1,311,937	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 1,311,937	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 3,346,152	32
33	Private Pay - Net Inpatient Revenue	1,101,720	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 4,447,872	37