

| | | | | | |
|--|--|-------------|--|--|--|
| | | 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: 100X138

Facility Name: Legancy Memory Support

Address: 4755 E Evergreen Crt Decatur 62521

County: Macon

Telephone Number: (217) 864-4300 Fax # ()

Federal Employer ID Number:

Date Current Owners were Certified: 2012

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

xx PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
xx Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: David M Underwood Telephone Number: (309 823-7135
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) David M. Underwood
(Title) EVP & CFO

Paid Preparer

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

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

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

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

/ /

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES ☐ NO ☒

(E.g., day care, "meals on wheels", outpatient therapy)

| | | | | |
|--------|----|----------|--|-------|
| ACCUAL | xx | MODIFIED | | |
| | | CASH* | | CASH* |

Tax Year: _____ **Fiscal Year:** _____

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.

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 94.79%

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.)

STATE OF ILLINOIS

Page 3

Facility Name: Legacy Memory Support

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 | 66,804 | 67,636 | | 134,440 | | 134,440 | 1 |
| 2 | Housekeeping, Laundry and Maintenance | 25,864 | 22,742 | | 48,606 | | 48,606 | 2 |
| 3 | Heat and Other Utilities | | | 55,076 | 55,076 | | 55,076 | 3 |
| 4 | Other (specify): | | | | | | | 4 |
| 5 | TOTAL General Services | 92,668 | 90,378 | 55,076 | 238,122 | | 238,122 | 5 |
| | B. Health Care and Programs | | | | | | | |
| 6 | Health Care/ Personal Care | 221,873 | 1,607 | 950 | 224,431 | | 224,431 | 6 |
| 7 | Activities and Social Services | 4,192 | 1,669 | | 5,861 | | 5,861 | 7 |
| 8 | Other (specify): | | | | | | | 8 |
| 9 | TOTAL Health Care and Programs | 226,065 | 3,276 | 950 | 230,292 | | 230,292 | 9 |
| | C. General Administration | | | | | | | |
| 10 | Administrative and Clerical | 75,921 | 4,919 | 59,185 | 140,025 | 3,954 | 143,979 | 10 |
| 11 | Marketing Materials, Promotions and Advertising | | | 17,864 | 17,864 | (13,805) | 4,060 | 11 |
| 12 | Employee Benefits and Payroll Taxes | | | 69,712 | 69,712 | | 69,712 | 12 |
| 13 | Insurance-Property, Liability and Malpractice | | | 8,048 | 8,048 | | 8,048 | 13 |
| 14 | Other (specify): | | | | | | | 14 |
| 15 | TOTAL General Administration | 75,921 | 4,919 | 154,810 | 235,650 | (9,851) | 225,799 | 15 |
| 16 | TOTAL Operating Expense (Sum of lines 5, 9 and 15) | 394,655 | 98,573 | 210,835 | 704,064 | (9,851) | 694,213 | 16 |
| | Capital Expenses | | | | | | | |
| | D. Ownership | | | | | | | |
| 17 | Depreciation | | | 79,448 | 79,448 | | 79,448 | 17 |
| 18 | Interest | | | 108,889 | 108,889 | (407) | 108,482 | 18 |
| 19 | Real Estate Taxes | | | 18,365 | 18,365 | | 18,365 | 19 |
| 20 | Rent -- Facility and Grounds | | | | | | | 20 |
| 21 | Rent -- Equipment | | | 8,520 | 8,520 | | 8,520 | 21 |
| 22 | Other (specify): | | | | | | | 22 |
| 23 | TOTAL Ownership | | | 215,222 | 215,222 | (407) | 214,815 | 23 |
| 24 | GRAND TOTAL (Sum of lines 16 and 23) | 394,655 | 98,573 | 426,058 | 919,286 | (10,258) | 909,028 | 24 |

Facility Name: Legacy Memory Support

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 | 1.25 | \$ 31.29 | 1 |
| 2 | Licensed Practical Nurses | 2.64 | 24.86 | 2 |
| 3 | Certified Nurse Assistants | 21.64 | 15.44 | 3 |
| 4 | Activity Director & Assistants | 0.67 | 12.37 | 4 |
| 5 | Social Service Workers | | | 5 |
| 6 | Head Cook | | | 6 |
| 7 | Cook Helpers/Assistants | 10.18 | 12.99 | 7 |
| 8 | Dishwashers | | | 8 |
| 9 | Maintenance Workers | 1.20 | 20.36 | 9 |
| 10 | Housekeepers | 2.27 | 11.76 | 10 |
| 11 | Laundry | | | 11 |
| 12 | Managers | | | 12 |
| 13 | Other Administrative | | | 13 |
| 14 | Clerical | 5.87 | 25.60 | 14 |
| 15 | Marketing | | | 15 |
| 16 | Other | | | 16 |
| 17 | Total (lines 1 thru 16) | 45.72 | \$ 17.08 | 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 |
|------|---|------|---|
| None | | | |
| | | | |
| | | | |
| | | | |

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).

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 | Heritage Enterprises Inc | 50.0% | | \$ 150,000 | 1 |
| 2 | Grand Oaks Estates LLC | 50.0% | | 150,000 | 2 |
| 3 | | | | | 3 |
| 4 | | | | | 4 |
| 5 | | | | | 5 |
| Total | | | | \$ 300,000 | 6 |

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

| | | | |
|-------|-------------------------------|-----------|---|
| 1 | Heritage Operations Group LLC | \$ 50,978 | 1 |
| 2 | | | 2 |
| Total | | \$ 50,978 | 3 |

Facility Name: Legacy Memory Support

Report Period Beginning:

1/1/2021

Ending:

12/31/2021

VIII. OWNERSHIP COSTSA. Purchase price of land 528,746 Year land was acquired 2012

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 | 113 | | | | \$ 10,601,024 | \$ 65,097 | | \$ 65,097 | | \$ 2,925,155 | 1 |
| 2 | | | | | | | | | | | 2 |
| 3 | | | | | | | | | | | 3 |
| 4 | | | | | | | | | | | 4 |
| 5 | | | | | | | | | | | 5 |
| Improvement Type | | | | | | | | | | | |
| 6 | Five (5) Eyewash Station Construction | | | 2013 | 3,392 | | | | | | 6 |
| 7 | Cable TV Installation-first installment | | | 2013 | 22,394 | | | | | | 7 |
| 8 | Cable TV Installation-second installment | | | 2014 | 28,210 | | | | | | 8 |
| 9 | Vertical PTAC cooler | | | 2016 | 4,705 | | | | | | 9 |
| 10 | Split system installation | | | 2017 | 5,957 | | | | | | 10 |
| 11 | Install flooring - common areas | | | 2017 | 18,113 | | | | | | 11 |
| 12 | Install smoke and CO2 detectors | | | 2017 | 12,937 | | | | | | 12 |
| 13 | Upgrade phone and fire panel | | | 2017 | 23,591 | | | | | | 13 |
| 14 | Split system installation | | | 2018 | 4,383 | | | | | | 14 |
| 15 | Carpet rolls for resident rooms | | | 2019 | 5,013 | | | | | | 15 |
| 16 | Ductless split system installation - elevator room | | | 2019 | 3,770 | | | | | | 16 |
| 17 | TOTAL (lines 1 thru 16) | | | | \$ 10,733,489 | \$ 65,097 | | \$ 65,097 | | \$ 2,925,155 | 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 | \$ 1,579,902 | \$ 9,224 | \$ 9,224 | | | \$ 1,543,188 | 18 |
| 19 | Vehicles | 47,850 | 5,127 | 5,127 | | | 5,127 | 19 |
| 20 | TOTAL (lines 18 and 19) | \$ 1,627,752 | \$ 14,351 | \$ 14,351 | | | \$ 1,548,315 | 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 |

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 | Totals from Page 5, Carried Forward | | \$ 10,733,489 | \$ 65,097 | | \$ 65,097 | \$ | \$ 2,925,155 | 1 |
| 2 | | | | | | | | | 2 |
| 3 | Acquire carpet roll for resident rooms | 2020 | 4,907 | | | | | | 3 |
| 4 | | | | | | | | | 4 |
| 5 | Install fire pump packing | 2021 | 2,592 | | | | | | 5 |
| 6 | Install (2) VTAC and (1) PTAC air handling units | 2021 | 9,262 | | | | | | 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 |
| 20 | | | | | | | | | 20 |
| 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) | | \$ 10,750,250 | \$ 65,097 | | \$ 65,097 | \$ | \$ 2,925,155 | 34 |

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

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: None

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 | Lancaster Pollard | | xx | Mortgage | / / | \$ | 10,628,962 | / / | | \$ 108,889 | 1 |
| 2 | | | | | / / | | | / / | | | 2 |
| 3 | | | | | / / | | | / / | | | 3 |
| | Working Capital | | | | | | | | | | |
| 4 | | | | | / / | | | / / | | | 4 |
| 5 | | | | | / / | | | / / | | | 5 |
| 6 | | | | | / / | | | / / | | | 6 |
| 7 | TOTAL Facility Related | | | | | \$ | 10,628,962 | | | \$ 108,889 | 7 |
| | B. Non-Facility Related | | | | | | | | | | |
| 8 | | | | | / / | | | / / | | -407 | 8 |
| 9 | | | | | / / | | | / / | | | 9 |
| 10 | TOTALS (lines 7, 8 and 9) | | | | | \$ | 10,628,962 | | | \$ 108,482 | 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: Legacy Memory Support

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 | \$ 1,896,974 | \$ | 1 |
| 2 | Cash-Patient Deposits | 24,585 | | 2 |
| 3 | Accounts & Short-Term Notes Receivable-Patients (less allowance) | (13,328) | | 3 |
| 4 | Supply Inventory (priced at) | 22,378 | | 4 |
| 5 | Short-Term Investments | | | 5 |
| 6 | Prepaid Insurance | 48,402 | | 6 |
| 7 | Other Prepaid Expenses | | | 7 |
| 8 | Accounts Receivable (owners or related parties) | | | 8 |
| 9 | Other(specify): | | | 9 |
| 10 | TOTAL Current Assets (sum of lines 1 thru 9) | \$ 1,979,011 | \$ | 10 |
| | B. Long-Term Assets | | | |
| 11 | Long-Term Notes Receivable | | | 11 |
| 12 | Long-Term Investments | | | 12 |
| 13 | Land | 2,005,702 | | 13 |
| 14 | Buildings, at Historical Cost | 10,750,250 | | 14 |
| 15 | Leasehold Improvements, at Historical Cost | | | 15 |
| 16 | Equipment, at Historical Cost | 1,627,752 | | 16 |
| 17 | Accumulated Depreciation (book methods) | (4,473,470) | | 17 |
| 18 | Deferred Charges | 450,871 | | 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) | \$ 10,361,105 | \$ | 24 |
| 25 | TOTAL ASSETS (sum of lines 10 and 24) | \$ 12,340,116 | \$ | 25 |

| | | 1 Operating | 2 After Consolidation* | |
|----|--|----------------|------------------------------|----|
| | C. Current Liabilities | | | |
| 26 | Accounts Payable | \$ 105,419 | \$ | 26 |
| 27 | Officer's Accounts Payable | | | 27 |
| 28 | Accounts Payable-Patient Deposits | | | 28 |
| 29 | Short-Term Notes Payable | | | 29 |
| 30 | Accrued Salaries Payable | | | 30 |
| 31 | Accrued Taxes Payable | 251,163 | | 31 |
| 32 | Accrued Interest Payable | 25,510 | | 32 |
| 33 | Deferred Compensation | | | 33 |
| 34 | Federal and State Income Taxes | | | 34 |
| | Other Current Liabilities(specify): | | | |
| 35 | Resident Trust | 24,585 | | 35 |
| 36 | | | | 36 |
| 37 | TOTAL Current Liabilities (sum of lines 26 thru 36) | \$ 406,677 | \$ | 37 |
| | D. Long-Term Liabilities | | | |
| 38 | Long-Term Notes Payable | | | 38 |
| 39 | Mortgage Payable | 10,628,962 | | 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) | \$ 10,628,962 | \$ | 44 |
| 45 | TOTAL LIABILITIES (sum of lines 37 and 44) | \$ 11,035,639 | \$ | 45 |
| 46 | TOTAL EQUITY | \$ 1,304,477 | \$ | 46 |
| 47 | TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46) | \$ 12,340,116 | \$ | 47 |

*(See instructions.)

Facility Name: Legacy Memory Support

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 | \$ 1,121,864 | 1 |
| 2 | Discounts and Allowances | | 2 |
| 3 | SUBTOTAL Resident Care (line 1 minus line 2) | \$ 1,121,864 | 3 |
| | B. Other Operating Revenue | | |
| 4 | Special Services | | 4 |
| 5 | Other Health Care Services | | 5 |
| 6 | Special Grants | 10,022 | 6 |
| 7 | Gift and Coffee Shop | | 7 |
| 8 | Barber and Beauty Care | 1,088 | 8 |
| 9 | Non-Resident Meals | | 9 |
| 10 | Laundry | | 10 |
| 11 | SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10) | \$ 11,111 | 11 |
| | C. Non-Operating Revenue | | |
| 12 | Contributions | | 12 |
| 13 | Interest and Other Investment Income | 407 | 13 |
| 14 | SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13) | \$ 407 | 14 |
| | D. Other Revenue (specify): | | |
| 15 | Miscellaneous/Activity Fund | (2,372) | 15 |
| 16 | | | 16 |
| 17 | SUBTOTAL Other Revenue (sum of lines 15 and 16) | \$ (2,372) | 17 |
| 18 | TOTAL REVENUE (sum of lines 3, 11, 14 and 17) | \$ 1,131,010 | 18 |

| | | 2 | |
|----|--|---------------|----|
| | II. Expenses | Amount | |
| | A. Operating Expenses | | |
| 19 | General Services | 238,122 | 19 |
| 20 | Health Care/ Personal Care | 230,292 | 20 |
| 21 | General Administration | 235,650 | 21 |
| | B. Capital Expense | | |
| 22 | Ownership | 215,222 | 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) | \$ 919,286 | 28 |
| 29 | Income Before Income Taxes (line 18 minus line 28) | \$ 211,724 | 29 |
| 30 | Income Taxes | \$ | 30 |
| 31 | NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30) | \$ 211,724 | 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 |

