

FOR BHF USE					

LL2

Supportive Living Facility

**2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2014)**

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>1000120</u></p> <p>Facility Name: <u>Greenview Place</u></p> <p>Address: <u>1501 West Melrose</u> <u>Chicago</u> <u>60657</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: (<u>773</u>) <u>525-1501</u> Fax # <u>(773) 269-6665</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>7/13/10</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 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 checked="" type="checkbox"/> Other <u>Limited Partnership</u></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 type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input checked="" type="checkbox"/> Other <u>Limited Partnership</u>	_____	<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>01/01/2014</u> to <u>12/31/2014</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%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> <td></td> </tr> <tr> <td></td> <td>(Title) _____</td> <td></td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</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 & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 517-7070</u></td> <td>Fax <u>(847) 517-7067</u></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>			(Telephone) <u>(847) 517-7070</u>	Fax <u>(847) 517-7067</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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<p>In the event there are further questions about this report, please contact:</p> <p>Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</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 Greenview Place

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	105	Single Unit Apartment	105	38,325	1
2		Double Unit Apartment			2
3		Other		2,190	3
4	105	TOTALS	105	40,515	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	32,730	2,731		35,461	5
6	Double Unit					6
7	Other	988			988	7
8	TOTALS	33,718	2,731		36,449	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 89.96%

D. Indicate the number of paid bed-hold days the SLF had during this year
498 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 24 (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? Note : Non-allowable costs have been eliminated in Schedule IV, Column 5.
 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

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO
 Tax Year: 12/31/14 Fiscal Year: 12/31/14

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? Yes If yes, did the facility make all of the required payments of interest and principle? Yes
 If no, explain. N/A

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? Yes If yes, did the facility make all of the required payments of interest and principle? Yes
 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 principle? N/A
 If no, explain. N/A

Facility Name: Greenview Place

Report Period Beginning:

01/01/2014

Ending: 12/31/2014

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	270,673	263,069		533,742	62,470	596,212	1
2	Housekeeping, Laundry and Maintenance	121,493	26,265	155,756	303,514		303,514	2
3	Heat and Other Utilities			154,199	154,199		154,199	3
4	Other (specify):			4,250	4,250	(4,250)	0	4
5	TOTAL General Services	392,165	289,335	314,205	995,705	58,220	1,053,925	5
B. Health Care and Programs								
6	Health Care/ Personal Care	332,264	5,429	298,768	636,461	(65,933)	570,528	6
7	Activities and Social Services	37,094	653	344	38,091		38,091	7
8	Other (specify):			60,000	60,000		60,000	8
9	TOTAL Health Care and Programs	369,358	6,082	359,112	734,551	(65,933)	668,618	9
C. General Administration								
10	Administrative and Clerical	334,363	18,994	245,336	598,694	(28,456)	570,238	10
11	Marketing Materials, Promotions and Advertising	63,959		20,617	84,576	(84,577)	(1)	11
12	Employee Benefits and Payroll Taxes			286,773	286,773		286,773	12
13	Insurance-Property, Liability and Malpractice			63,631	63,631		63,631	13
14	Other (specify):							14
15	TOTAL General Administration	398,322	18,994	616,358	1,033,674	(113,033)	920,642	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,159,845	314,411	1,289,674	2,763,930	(120,746)	2,643,184	16
Capital Expenses								
D. Ownership								
17	Depreciation			611,700	611,700		611,700	17
18	Interest			515,866	515,866	(3,670)	512,196	18
19	Real Estate Taxes			99,442	99,442		99,442	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			3,947	3,947		3,947	21
22	Other (specify):			568,902	568,902	(568,901)	1	22
23	TOTAL Ownership			1,799,857	1,799,857	(572,571)	1,227,286	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,159,845	314,411	3,089,530	4,563,786	(693,317)	3,870,470	24

Facility Name: Greenview Place

Report Period Beginning 01/01/2014 Ending: 12/31/2014

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			2
3	Certified Nurse Assistants	13.70	10.28	3
4	Activity Director & Assistants	1.00	20.33	4
5	Social Service Workers			5
6	Head Cook	2.81	13.15	6
7	Cook Helpers/Assistants			7
8	Dishwashers	9.43	9.44	8
9	Maintenance Workers	2.97	19.23	9
10	Housekeepers			10
11	Laundry			11
12	Managers	3.25	27.32	12
13	Other Administrative			13
14	Clerical	2.84	12.65	14
15	Marketing	1.00	30.78	15
16	Other			16
17	Total (lines 1 thru 16)	37.00	\$ 17.90	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	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

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 Attached Schedule 1 (A)			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
N/A					

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? \$ N/A

(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: Greenview Place

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land 545,000 Year land was acquired 2009

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	105			2009	\$ 21,440,300	\$ 585,700	40	\$ 585,700	\$	\$ 2,806,213	1
2				2009	520,000	26,000	20	26,000		143,000	2
3											3
4											4
5											5
Improvement Type											
6											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)				\$ 21,960,300	\$ 611,700		\$ 611,700	\$	\$ 2,949,213	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	\$ 461,103	\$ 44,410	\$ 44,410	\$	10	\$ 187,351	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 461,103	\$ 44,410	\$ 44,410	\$		\$ 187,351	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	N/A	\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: Greenview Place

Report Period Beginning: 01/01/2014

Ending: 2/31/2014

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			/ /	\$ N/A			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 \$ 3,947

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	DOH: Home Mortgage		X	Mortgage	4/1/08	\$ 2,800,000	\$ 2,800,000	6/1/48	0.0300	\$ 74,000
2	FHLB Mortgage		X	Mortgage	4/1/08	500,000	500,000	6/1/40		
3	Total from Attachment 2 (line 14)				/ /	14,900,000	9,970,000	/ /		336,229
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 18,200,000	\$ 13,270,000			\$ 410,229
	B. Non-Facility Related									
8					/ /	Amortization loan fees		/ /		15,000
9					/ /	Total from attachment 2 (line 19)		/ /		86,967
10	TOTALS (lines 7, 8 and 9)					\$ 18,200,000	\$ 13,270,000			\$ 512,196

* 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: **Greenview Place**Report Period Beginning: **01/01/2014**

Ending:

12/31/2014**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2014**

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 155,306	\$ 155,306	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u>)	918,223	918,223	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments	1,118,785	1,118,785	5
6	Prepaid Insurance	40,115	40,115	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,232,430	\$ 2,232,430	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	545,000	545,000	13
14	Buildings, at Historical Cost	21,440,300	21,440,300	14
15	Leasehold Improvements, at Historical Cost	520,000	520,000	15
16	Equipment, at Historical Cost	461,103	461,103	16
17	Accumulated Depreciation (book methods)	(3,136,564)	(3,136,564)	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): Bond Costs	192,373	192,373	22
23	Other(specify): Legal Fees & Leasing	138,840	138,840	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 20,161,052	\$ 20,161,052	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 22,393,482	\$ 22,393,482	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 39,449	\$ 39,449	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	105,000	105,000	31
32	Accrued Interest Payable	616,102	616,102	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Attachment 1B	97,918	97,918	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 858,469	\$ 858,469	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,300,000	4,300,000	39
40	Bonds Payable	8,780,000	8,780,000	40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	See Attachment 1C	1,468,371	1,468,371	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 14,548,371	\$ 14,548,371	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 15,406,840	\$ 15,406,840	45
46	TOTAL EQUITY	\$ 6,986,643	\$ 6,986,643	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 22,393,482	\$ 22,393,482	47

*(See instructions.)

Facility Name: Greenview Place

Report Period Beginning: 01/01/2014

Ending:

12/31/2014

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 3,620,522	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,620,522	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	3,463	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 3,463	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	3,670	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 3,670	14
D. Other Revenue (specify):			
15	See Attachment #1D	65,763	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 65,763	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,693,419	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	995,705	19
20	Health Care/ Personal Care	734,551	20
21	General Administration	1,033,674	21
B. Capital Expense			
22	Ownership	1,799,857	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)	\$ 4,563,786	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (870,367)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (870,367)	31

Renaissance Saint Luke SLF, LP (D/B/A Greenview Place)
04-3848145

Supplementary Information - Attachment 1

12/31/2014

(A) **Sch. VII-Related Parties-Related Nursing Homes**

<u>Name</u>	<u>City</u>
Renaissance Realty	Chicago, IL
RRG Development	Chicago, IL
St Luke Church	Chicago, IL
Lutheran Community Services For The Aged, Inc	Chicago, IL
National Equity Fund	Chicago, IL
St. Luke Housing Ministries	Chicago, IL

(B) **Sch. XI-Balance Sheet-Line 35: Other Current Liabilities**

	<u>Operating</u>	<u>After Consolidation</u>
Accrued Asset Management fee	79,146	79,146
Security Deposit	6,119	6,119
Pet Deposit	2,377	2,377
Tenant Prepaid Rent	5,510	5,510
Tenant Deposits - Clearing	4,767	4,767
	<u>97,919</u>	<u>97,919</u>

(C) **Sch. XI-Balance Sheet-Line 42: Other Long-Term Liabilities**

	<u>Operating</u>	<u>After Consolidation</u>
Accrued Developers Fee	71,645	71,645
Accrued Unrealized Loss on Swap	1,396,726	1,396,726
	<u>1,468,371</u>	<u>1,468,371</u>

(D) **Sch. XII. Income Statement-Line 15: Other Revenue**

Amount

Late Fees	34
NSF Fee	70
Parking	37,181
Key & Lock Charges	30
Miscellaneous Income	28,366
Pet Usage Fee	82
	<u>65,763</u>

Renaissance Saint Luke SLF, LP (D/B/A Greenview Place)

Interest Expense (continued)

12/31/2014

Attachment 2

	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											
3	IHDA Trust Fund Mortgage		X	Mortgage	4/1/08	\$ 1,000,000	\$ 1,000,000	6/1/40	0.0100	\$ 10,000	3
4	Series A Bond		X	Mortgage	4/1/08	13,900,000	8,970,000	6/1/40	0.0363	326,229	4
5	Total (Attachment 2) to Schedule X - Line 14				/ /	14,900,000	9,970,000	/ /		336,229	5
B. Non-Facility Related											
8					/ /	Interest Income		/ /		(3,670)	8
9					/ /	Letter of Credit Expense		/ /		90,637	9
	Total (Attachment 2) to Schedule X - Line 19									86,967	