

		FOR BHF USE			

LL2

Supportive Living Facility

**2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2008)**

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.</p> <p>Facility Name: <u>Glenhaven Gardens Alton</u></p> <p>Address: <u>100 Glenhaven Drive</u> <u>Alton</u> <u>62002</u> <small>Number City Zip Code</small></p> <p>County: <u>Madison</u></p> <p>Telephone Number: (<u>618</u>) <u>462-1500</u> Fax # (<u>618</u>) <u>462-1511</u></p> <p>Federal Employer ID Number: <u>35-2284218</u></p> <p>Date Current Owners were Certified: <u>4/22/08</u></p> <p>Type of Ownership:</p> <table border="0"> <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> <p>In the event there are further questions about this report, please contact: Name: <u>Matthew Whitlock</u> Telephone Number: <u>(618) 462-1500</u> Email Address: <u>adm_gga@charterinternet.com</u></p>	<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>4/22/08</u> to <u>12/31/08</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 border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Matthew Whitlock</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Administrator</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>See Attached Compilation Report</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Steven R. Grohne, CPA Partner</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>May, Cocagne & King, P.C. 1353 E. Mound Road, Suite 204, Decatur, IL 62526</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(217) 875-2655</u> Fax <u>(217) 876-0090</u></td> <td></td> </tr> </table> <p align="right">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>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Matthew Whitlock</u>			(Title) <u>Administrator</u>		Paid Preparer	(Signed) <u>See Attached Compilation Report</u>	(Date) _____	(Print Name and Title) <u>Steven R. Grohne, CPA Partner</u>		(Firm Name & Address) <u>May, Cocagne & King, P.C. 1353 E. Mound Road, Suite 204, Decatur, IL 62526</u>		(Telephone) <u>(217) 875-2655</u> Fax <u>(217) 876-0090</u>	
<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 _____																																									
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																								
	(Type or Print Name) <u>Matthew Whitlock</u>																																									
	(Title) <u>Administrator</u>																																									
Paid Preparer	(Signed) <u>See Attached Compilation Report</u>	(Date) _____																																								
	(Print Name and Title) <u>Steven R. Grohne, CPA Partner</u>																																									
	(Firm Name & Address) <u>May, Cocagne & King, P.C. 1353 E. Mound Road, Suite 204, Decatur, IL 62526</u>																																									
	(Telephone) <u>(217) 875-2655</u> Fax <u>(217) 876-0090</u>																																									

Facility Name Glenhaven Gardens Alton

Report Period Beginning: 4/22/08 Ending: 12/31/08

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	13	Single Unit Apartment	13	3,302	1
2	79	Double Unit Apartment	79	20,066	2
3		Other		254	3
4	92	TOTALS	92	23,622	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	164	370		534	5
6	Double Unit	5,274	2,694		7,968	6
7	Other					7
8	TOTALS	5,438	3,064		8,502	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 35.99%

D. Indicate the number of paid bed-hold days the SLF had during this year 138 Also, indicate the number of unpaid bed-hold days the SLF had during this year. _____ **(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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

* 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 principle? _____

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 principle? _____

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 principle? _____

If no, explain. _____

Facility Name: Glenhaven Gardens Alton

Report Period Beginning:

4/22/08

Ending:

12/31/08

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	75,373	54,478	825	130,676	(130)	130,546	1
2	Housekeeping, Laundry and Maintenance	37,816	4,081	7,923	49,820		49,820	2
3	Heat and Other Utilities			64,201	64,201	(10,946)	53,255	3
4	Other (specify):			6,732	6,732		6,732	4
5	TOTAL General Services	113,189	58,559	79,681	251,429	(11,076)	240,353	5
B. Health Care and Programs								
6	Health Care/ Personal Care	142,908	1,121		144,029		144,029	6
7	Activities and Social Services	17,125		895	18,020	(350)	17,670	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	160,033	1,121	895	162,049	(350)	161,699	9
C. General Administration								
10	Administrative and Clerical	79,009	5,888	48,220	133,117	(5,186)	127,931	10
11	Marketing Materials, Promotions and Advertising	39,518		33,384	72,902		72,902	11
12	Employee Benefits and Payroll Taxes			55,541	55,541		55,541	12
13	Insurance-Property, Liability and Malpractice			32,554	32,554		32,554	13
14	Other (specify):			17,496	17,496		17,496	14
15	TOTAL General Administration	118,527	5,888	187,195	311,610	(5,186)	306,424	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	391,749	65,568	267,771	725,088	(16,612)	708,476	16
Capital Expenses								
D. Ownership								
17	Depreciation			323,307	323,307		323,307	17
18	Interest			439,453	439,453	(13,797)	425,656	18
19	Real Estate Taxes			45,000	45,000		45,000	19
20	Rent -- Facility and Grounds			43,148	43,148		43,148	20
21	Rent -- Equipment							21
22	Other (specify):			244,974	244,974	(186,254)	58,720	22
23	TOTAL Ownership			1,095,882	1,095,882	(200,051)	895,831	23
24	GRAND TOTAL (Sum of lines 16 and 23)	391,749	65,568	1,363,653	1,820,970	(216,663)	1,604,307	24

Facility Name: Glenhaven Gardens Alton

Report Period Beginning: 4/22/08 Ending: 12/31/08

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 24.76	1
2	Licensed Practical Nurses	1	18.50	2
3	Certified Nurse Assistants	9	10.00	3
4	Activity Director & Assistants	1	12.00	4
5	Social Service Workers			5
6	Head Cook	1	14.42	6
7	Cook Helpers/Assistants	2	9.00	7
8	Dishwashers	4	7.75	8
9	Maintenance Workers	1	17.42	9
10	Housekeepers	2	8.00	10
11	Laundry			11
12	Managers	1	28.85	12
13	Other Administrative	1	14.42	13
14	Clerical	1	7.75	14
15	Marketing	1	20.19	15
16	Other			16
17	Total (lines 1 thru 16)	26	\$ 12.05	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 <u>1</u>	City <u>2</u>
Glenhaven Management, LLC	Bloomington, Illinois
Yorkville S.L.F., LLC	Yorkville, Illinois
Prairie Winds of Urbana, L.P.	Urbana, Illinois
Eagle Ridge of Decatur S.L.F., LLC	Decatur, Illinois

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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: Glenhaven Gardens Alton

Report Period Beginning: 4/22/08

Ending: 12/31/08

VIII. OWNERSHIP COSTS

A. Purchase price of land N/A - Land lease Year land was acquired N/A - Land lease

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	92			2008	\$ 7,717,798	\$ 187,098	28	\$ 187,098	\$	\$ 187,098	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Exterior Signage and Irrigation Supplies		2008	8,012	356	15	356		356	6
7		Site Improvements		2008	185,687	8,253	15	8,253		8,253	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)				\$ 7,911,497	\$ 195,707		\$ 195,707	\$	\$ 195,707	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	\$ 949,153	\$ 122,644	\$ 122,644	\$	3-7	\$ 122,644	18
19	Vehicles	37,168	4,956	4,956		5	4,956	19
20	TOTAL (lines 18 and 19)	\$ 986,321	\$ 127,600	\$ 127,600	\$		\$ 127,600	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: Glenhaven Gardens Alton

Report Period Beginning: 4/22/08

Ending: 12/31/08

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Alton Memorial Hospital

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	Land		5/1/08	5,394	50	Two 10-year renewals	5
6			/ /				6
7	TOTAL			\$ 5,394			7

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

9. Rental amount for movable equipment \$ 1,932

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				
		YES	NO			Original	Balance				
A. Directly Facility Related Long-Term											
1	First Bank		X	Purchase/Construction of Facility	12/1/06	\$	\$ 7,938,696	6/1/11	0.0719	\$ 393,734	1
2					/ /			/ /			2
3					/ /			/ /			3
Working Capital											
4	Various Lenders		X	Operating Lines of Credit	Various		500,000	7/29/09	0.0425	32,198	4
5	Glenhaven Mgmt LLC	X		Operating Advances	Various			Paid Off	0.0650	13,521	5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	\$ 8,438,696			\$ 439,453	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	\$ 8,438,696			\$ 439,453	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

Facility Name: **Glenhaven Gardens Alton**

Report Period Beginning: **4/22/08**

Ending: **12/31/08**

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/08**

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 68,518	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance \$ - 0 -)	197,880		3
4	Supply Inventory (priced at cost)	83		4
5	Short-Term Investments			5
6	Prepaid Insurance	9,045		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	11,498		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 287,024	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	7,717,798		14
15	Leasehold Improvements, at Historical Cost	193,699		15
16	Equipment, at Historical Cost	986,321		16
17	Accumulated Depreciation (book methods)	(323,307)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	189,932		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(30,066)		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)	\$ 8,734,377	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,021,401	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 38,425	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,628		28
29	Short-Term Notes Payable	630,213		29
30	Accrued Salaries Payable	17,696		30
31	Accrued Taxes Payable	45,000		31
32	Accrued Interest Payable	49,170		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
Other Current Liabilities(specify):				
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 783,132	\$	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable	7,808,483		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)	\$ 7,808,483	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,591,615	\$	45
46	TOTAL EQUITY	\$ 429,786	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,021,401	\$	47

*(See instructions.)

Facility Name: Glenhaven Gardens Alton

Report Period Beginning: 4/22/08

Ending:

12/31/08

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	\$ 703,897	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 703,897	3
B. Other Operating Revenue			
4	Special Services	9,741	4
5	Other Health Care Services	1,482	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	3,096	8
9	Non-Resident Meals	2,462	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 16,781	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	13,797	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 13,797	14
D. Other Revenue (specify):			
15	Vending receipts	26	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 26	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 734,501	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	251,429	19
20	Health Care/ Personal Care	162,049	20
21	General Administration	311,610	21
B. Capital Expense			
22	Ownership	1,095,882	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)	\$ 1,820,970	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (1,086,469)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (1,086,469)	31

IV. COST CENTER EXPENSES

Operating Expenses

A. General Services

<u>Line 4 - Other (specify) / Column 6</u>	
Rubbish removal	826
Vehicle & equipment operating expense	5,832
Miscellaneous - operating	19
Mileage - screening	55
	<u>6,732</u>

C. General Administration

<u>Line 14 - Other (specify) / Column 6</u>	
Professional fees - legal	460
Professional fees - accounting	4,877
Background checks	537
Bank service charges	1,052
Beauty shop	3,508
Dues and subscriptions	892
Help wanted ads	1,841
Licenses/permits	667
Promotion - meals	40
Promotion - travel	41
Training/education	1,048
Uniforms	286
Miscellaneous - other admin	2,247
	<u>17,496</u>

Capital Expenses

D. Ownership

<u>Line 22 - Other (specify) / Column 6</u>	
Amortization of loan fees	15,324
Amortization of ground lease legal fees	154
Amortization of organization costs	14,588
Amortization of pre-opening costs	28,654
	<u>58,720</u>

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

In 2008, Glenhaven Management, LLC (a related organization) paid Linda Allison \$81,000. An average of 30 hours per week of her time is related to Glenhaven Gardens of Alton, LLC. Linda Allison is a 5% owner of Glenhaven Gardens of Alton, LLC.

VII. RELATED ORGANIZATIONS

C. Does page 3 include any costs derived from transactions (including rent) with related parties?

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).

Related Organization	Expense	Facility Book Value	Actual Cost
Glenhaven Management, LLC	Property Management Fees	29,432	29,432
Glenhaven Management, LLC	Interest Expense	13,521	13,521

XII. INCOME STATEMENT - Reconciliation of Total Cost Center Expenses on Schedule IV to Total Expenses on Schedule XII.

Total Cost Center Expenses, Schedule IV	1,604,307
Alcohol purchases	130
Cable expenses - Resident rooms	10,946
Entertainment expenses	350
Resident telephone revenue offset against total telephone expense	5,186
Interest income offset against interest expense	13,797
Pre-opening costs	214,908
Amortization of pre-opening costs	(28,654)
Total Expenses, Schedule XII	<u>1,820,970</u>