

		FOR BHF USE			

LL2

Supportive Living Facility

**2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2015)**

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</u>) <u>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>01/01/2015</u> to <u>12/31/2015</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) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) (<u>847</u>) <u>517-7070</u> Fax (<u>847</u>) <u>517-7067</u></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) (<u>847</u>) <u>517-7070</u> Fax (<u>847</u>) <u>517-7067</u>
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<p>In the event there are further questions about this report, please contact: Name: <u>Amanda Springborn</u> Telephone Number: (<u>314</u>) <u>925-3838</u> 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: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

Date of change in certified units 1 / 01 / 2015

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
		Greenview Place			
1	105	Single Unit Apartment	99	36,135	1
2	1501 West Melrose	Double Unit Apartment	6	4,380	2
3		Other		2,190	3
4	105	TOTALS	105	42,705	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	33,582	2,365		35,947	5
6	Double Unit					6
7	Other	710			710	7
8	TOTALS	34,292	2,365		36,657	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 85.84%

D. Indicate the number of paid bed-hold days the SLF had during this year 327 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 5 (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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

* 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:

01/01/2015

Ending: 12/31/2015

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	265,377	247,242		512,619	65,092	577,711	1
2	Housekeeping, Laundry and Maintenance	115,877	30,256	144,368	290,501		290,501	2
3	Heat and Other Utilities			158,140	158,140		158,140	3
4	Other (specify):			3,885	3,885		3,885	4
5	TOTAL Gener Greenview Place	381,254	277,498	306,393	965,146	65,092	1,030,238	5
B. Health Care and Programs								
6	Health C: 1501 West Melrose	316,358	5,576	305,571	627,505	(65,933)	561,572	6
7	Activities and Social Services	34,297	168		34,465		34,465	7
8	Other (specify):			60,000	60,000		60,000	8
9	TOTAL Health Care and Programs	350,655	5,743	365,571	721,970	(65,933)	656,037	9
C. General Administration								
10	Administrative and Clerical	402,349	19,158	426,884	848,390	(13,656)	834,734	10
11	Marketing Materials, Promotions and Advertising	69,903		16,734	86,637	(86,637)	0	11
12	Employee Benefits and Payroll Taxes			278,024	278,024		278,024	12
13	Insurance-Property, Liability and Malpractice			62,449	62,449		62,449	13
14	Other (specify):							14
15	TOTAL General Administration	472,252	19,158	784,091	1,275,501	(100,293)	1,175,208	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,204,161	302,399	1,456,056	2,962,616	(101,134)	2,861,482	16
Capital Expenses								
D. Ownership								
17	Depreciation			611,700	611,700		611,700	17
18	Interest			510,324	510,324	(4,515)	505,809	18
19	Real Estate Taxes			108,441	108,441		108,441	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			3,629	3,629		3,629	21
22	Other (specify):			154,101	154,101	(154,102)	(0)	22
23	TOTAL Ownership			1,388,196	1,388,196	(158,617)	1,229,580	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,204,161	302,399	2,844,252	4,350,812	(259,750)	4,091,062	24

Facility Name: Greenview Place

Report Period Beginning 01/01/2015 Ending: 12/31/2015

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	14.44	10.21	3
4	Activity Director & Assistants	0.75	21.18	4
5	Social Service Workers			5
6	Head Cook	2.47	13.16	6
7	Cook Helpers/Assistants Greenview Place			7
8	Dishwashers	8.45	10.00	8
9	Maintenan 1501 West Melrose	2.64	18.62	9
10	Housekeepers			10
11	Laundry			11
12	Managers	4.00	27.28	12
13	Other Administrative			13
14	Clerical	1.98	12.59	14
15	Marketing	1.00	32.22	15
16	Other			16
17	Total (lines 1 thru 16)	35.73	\$ 18.16	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:

01/01/2015

Ending:

12/31/2015

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	\$ 541,290	40	\$ 541,290	\$	\$ 3,347,503	1
2				2009	520,000	26,000	20	26,000		169,000	2
3											3
4											4
5											5
	Improv. Greenview Place										
6											6
7		1501 West Melrose									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	\$ 567,290		\$ 567,290	\$	\$ 3,516,503	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	\$ 231,761	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 461,103	\$ 44,410	\$ 44,410	\$		\$ 231,761	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: 01/01/2015

Ending: 12/31/2015

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	Greenview Place	/ /				4
5			/ /				5
6	1501 West Melrose		/ /				6
7	TOTAL			\$			7

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

9. Rental amount for movable equipment \$ 3,629

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
		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	1	
2	FHLB Mortgage		X	Mortgage	4/1/08	500,000	500,000	6/1/40			2	
3	Total from Attachment 2 (line 5)				/ /	14,900,000	9,630,000	/ /		332,222	3	
Working Capital												
4					/ /			/ /			4	
5					/ /			/ /			5	
6					/ /			/ /			6	
7	TOTAL Facility Related					\$ 18,200,000	\$ 12,930,000			\$ 406,222	7	
B. Non-Facility Related												
8					/ /	Amortization Loan Fees		/ /		15,000	8	
9					/ /	Total from Attachment 2 (line 10)		/ /		84,586	9	
10	TOTALS (lines 7, 8 and 9)					\$ 18,200,000	\$ 12,930,000			\$ 505,809	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: **Greenview Place**Report Period Beginning: **01/01/2015**

Ending:

12/31/2015**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2015**

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 434,369	\$ 434,369	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	929,259	929,259	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,229,068	1,229,068	5
6	Prepaid Insurance Greenview Place	(33,882)	(33,882)	6
7	Other Prepaid Expenses			7
8	Accounts Recei 1501 West Melrose			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,558,813	\$ 2,558,813	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)	(3,748,264)	(3,748,264)	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):	177,373	177,373	22
23	Other(specify): See Attachment #1B	139,912	139,912	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 19,535,424	\$ 19,535,424	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 22,094,237	\$ 22,094,237	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 48,565	\$ 48,565	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	107,000	107,000	31
32	Accrued Interest Payable	690,102	690,102	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Attachment #1C	118,434	118,434	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 964,102	\$ 964,102	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,300,000	4,300,000	39
40	Bonds Payable	8,630,000	8,630,000	40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	See Attachment #1D	1,672,280	1,672,280	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 14,602,280	\$ 14,602,280	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 15,566,382	\$ 15,566,382	45
46	TOTAL EQUITY	\$ 6,527,856	\$ 6,527,856	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 22,094,237	\$ 22,094,237	47

*(See instructions.)

Facility Name: Greenview Place

Report Period Beginning: 01/01/2015

Ending:

12/31/2015

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

	1	Amount	
	Revenue		
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 3,843,385	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	Greenview Place \$ 3,843,385	3
	B. Other (1501 West Melrose)		
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	841	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 841	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	4,515	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 4,515	14
	D. Other Revenue (specify):		
15	See Attachment #1E	43,304	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 43,304	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,892,045	18

	2	Amount	
	Expenses		
	A. Operating Expenses		
19	General Services	965,146	19
20	Health Care/ Personal Care	721,970	20
21	General Administration	1,275,501	21
	B. Capital Expense		
22	Ownership	1,388,196	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)	\$ 4,350,812	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (458,767)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (458,767)	31

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

Supplementary Information - Attachment 1
12/31/2015

(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	Greenview Place

1501 West Melrose

(B) Sch. XI-Balance Sheet-Line 23: Other Current Liabilities

	<u>Operating</u>	<u>After Consolidation</u>
Legal Fees: Syndicator	33,000	33,000
Marketing and Leasing	100,000	100,000
Tax Credit Fees	5,840	5,840
Parking Deposit	1,000	1,000
Suspense	72	72
	<u>139,912</u>	<u>139,912</u>

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

	<u>Operating</u>	<u>After Consolidation</u>
Accrued Management Fee	105,947	105,947
Security Deposit	3,648	3,648
Pet Deposit	152	152
Tenant Prepaid Rent	779	779
Tenant Deposits - Clearing	7,887	7,887
Clearing Account	21	21
HFS Suspense	1	1

118,434	118,434
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(D)	<u>Sch. XI-Balance Sheet-Line 42: Other Long-Term Liabilities</u>	<u>Operating</u>	<u>After Consolidation</u>
	Accrued Developers Fee	21,645	21,645
	Accrued Partnership Management Fee	170,000	170,000
	Accrued Unrealized Loss on Swap	1,480,635	1,480,635
		<u>1,672,280</u>	<u>1,672,280</u>

(E)	<u>Sch. XII. Income Statement-Line 15: Other Revenue</u>	<u>Amount</u>
	Late Fees	90
	NSF Fee	25
	Parking	29,418
	Key & Lock Charges	50
	Miscellaneous Income	13,656
	Pet Usage Fee	65
		<u>43,304</u>

Renaissance Saint Luke SLF, LP (D/B/A Greenview Place)
 Interest Expense (continued)
 12/31/2015 Attachment 2

	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		
		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	
4	Series A Bond		X	Mortgage	4/1/08	13,900,000	8,630,000	
5	Total (Attachment 2) to Schedule X - Line 3				/ /	14,900,000	9,630,000	
Greenview Place								
B. Non-Facility Related								
8	1501 West Melrose				/ /	Interest Income		
9					/ /	Letter of Credit Expense		
	Total (Attachment 2) to Schedule X - Line 9							

Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
6/1/40	0.0100	\$ 10,000	3
6/1/40	0.0363	322,222	4
/ /		332,222	5

/ /		(4,515)	8
/ /		89,101	9
		84,586	