

		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>1000035</u></p> <p>Facility Name: <u>The Manor at Mason Woods</u></p> <p>Address: <u>223 Illinois Street</u> <u>Pinckneyville</u> <u>62274</u> <small>Number City Zip Code</small></p> <p>County: <u>Perry</u></p> <p>Telephone Number: (<u>618</u>) <u>357-9770</u> Fax # <u>618 357-9774</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>5/17/2004</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input checked="" type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Deborah J Edwards</u> Telephone Number: (<u>618</u>) <u>233-1001</u> Email Address: _____</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 checked="" 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 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>1/1/15</u> to <u>12/31/15</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%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>J. Michael Greer</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Title) <u>Partner</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Firm Name & Address) <u>Creason-Edwards & Cimarolli, PC</u> <u>4000 N Belt West, Belleville, IL 62226</u></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Telephone) <u>618</u>) <u>233-1001</u> Fax <u>618-233-6009</u></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>J. Michael Greer</u>			(Title) <u>Partner</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u>			(Firm Name & Address) <u>Creason-Edwards & Cimarolli, PC</u> <u>4000 N Belt West, Belleville, IL 62226</u>			(Telephone) <u>618</u>) <u>233-1001</u> Fax <u>618-233-6009</u>	
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Facility Name The Manor at Mason Woods

Report Period Beginning: 1/1/15 Ending: 12/31/15

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	30	Single Unit Apartment	30	10,950	1
2	10	Double Unit Apartment	10	3,650	2
3		Other			3
4	40	TOTALS	40	14,600	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	4,961	4,520		9,481	5
6	Double Unit	763	2,678		3,441	6
7	Other					7
8	TOTALS	5,724	7,198		12,922	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.51%

D. Indicate the number of paid bed-hold days the SLF had during this year 383 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)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 2015 Fiscal Year:

* 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. _____

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: The Manor at Mason Woods

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	99,420	85,853	1,669	186,942	(207)	186,735	1
2	Housekeeping, Laundry and Maintenance	49,938	16,487	12,300	78,725		78,725	2
3	Heat and Other Utilities			35,424	35,424	(2,270)	33,154	3
4	Other (specify): Waste removal			2,898	2,898		2,898	4
5	TOTAL General Services	149,357	102,340	52,290	303,988	(2,477)	301,511	5
B. Health Care and Programs								
6	Health Care/ Personal Care	211,031	8,054	1,625	220,710		220,710	6
7	Activities and Social Services	26,820	8,610	740	36,170	(740)	35,430	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	237,851	16,664	2,365	256,880	(740)	256,140	9
C. General Administration								
10	Administrative and Clerical	65,416	6,355	94,886	166,657		166,657	10
11	Marketing Materials, Promotions and Advertising		18,671	15,564	34,235		34,235	11
12	Employee Benefits and Payroll Taxes			68,386	68,386		68,386	12
13	Insurance-Property, Liability and Malpractice			18,388	18,388		18,388	13
14	Other (specify):							14
15	TOTAL General Administration	65,416	25,026	197,224	287,666		287,666	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	452,624	144,030	251,879	848,534	(3,217)	845,317	16
Capital Expenses								
D. Ownership								
17	Depreciation			105,204	105,204		105,204	17
18	Interest			48,697	48,697		48,697	18
19	Real Estate Taxes			35,730	35,730		35,730	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			4,403	4,403	(4,000)	403	21
22	Other (specify):			3,627	3,627	(3,123)	504	22
23	TOTAL Ownership			197,661	197,661	(7,123)	190,538	23
24	GRAND TOTAL (Sum of lines 16 and 23)	452,624	144,030	449,540	1,046,195	(10,340)	1,035,855	24

Facility Name: The Manor at Mason Woods

Report Period Beginning 1/1/15

Ending: 12/31/15

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 25.00	1
2	Licensed Practical Nurses	3	15.41	2
3	Certified Nurse Assistants	5	10.00	3
4	Activity Director & Assistants	1	13.40	4
5	Social Service Workers			5
6	Head Cook	1	11.92	6
7	Cook Helpers/Assistants	3	10.14	7
8	Dishwashers	1	9.02	8
9	Maintenance Workers	1	10.35	9
10	Housekeepers	1	8.99	10
11	Laundry	1	9.34	11
12	Managers	1	22.32	12
13	Other Administrative			13
14	Clerical	1	11.08	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	20	\$	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

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>
The Prairies	Carbondale
Clinton Manor Nursing Home	New Baden
See attached schedule	

OTHER RELATED BUSINESS ENTITIES

Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
Greer Management Services	Carlyle	Management Co

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: The Manor at Mason Woods

Report Period Beginning:

1/1/15

Ending:

12/31/15

VIII. OWNERSHIP COSTS

A. Purchase price of land 35,822 Year land was acquired 2003

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	30		2004	2004	\$ 1,879,570	\$ 68,348	28	\$ 68,348	\$	\$ 791,698	1
2	10		2006	2006	520,000	13,334	28	13,334		132,778	2
3											3
4											4
5											5
Improvement Type											
6	Door Opener		2004		3,128	114	28	114		1,261	6
7	Hand Rails		2005		2,382	87	28	87		924	7
8	Automatic Door Opener		2005		3,362	122	28	122		1,263	8
9	Vinyl Flooring		2008		6,823		5			6,823	9
10	Flooring - Dining Room		2013		11,620	2,324	5	2,324		6,972	10
11	Flooring - 400 Wing		2013		6,598	1,320	5	1,320		3,079	11
12	Roof Repair		2014		83,825	3,048	28	3,048		3,810	12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 2,517,308	\$ 88,697		\$ 88,697	\$	\$ 948,607	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	\$ 168,725	\$ 16,509	\$ 16,509	\$	5	\$ 124,128	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)		\$ 168,725	\$ 16,509	\$ 16,509		\$ 124,128	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: The Manor at Mason Woods

Report Period Beginning: 1/1/15

Ending: 12/31/15

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Greer Management Services (Vehicle Lease)

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 \$ 4,403

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	Name of Lender	2		3	4	6		7	8	9	
			Related**	YES			NO	Purpose of Loan				
							Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		Murphy Wall State Bank	X		Mortgage	6/30/03	\$ 490,000	\$ 266,813	6/30/23	6.9200	\$ 19,732	1
2		IL Hsg Development Auth		X	Mortgage	6/30/03	750,000	542,895	1/1/25	1.0000	5,598	2
3		See attachment				/ /	630,000	496,867	/ /		23,367	3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 1,870,000	\$ 1,306,575			\$ 48,697	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 1,870,000	\$ 1,306,575			\$ 48,697	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: The Manor at Mason Woods

Report Period Beginning: 1/1/15

Ending:

12/31/15

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 442,849	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 11,805)	131,358		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,329		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)	\$ 602,536	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,822		13
14	Buildings, at Historical Cost	2,517,307		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	168,725		16
17	Accumulated Depreciation (book methods)	(1,072,735)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	80,752		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(29,509)		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)	\$ 1,700,362	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,302,898	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,835	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,574		30
31	Accrued Taxes Payable	36,707		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Other Accrued Liabilities	32,008		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 92,123	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	1,306,576		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)	\$ 1,306,576	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,398,699	\$	45
46	TOTAL EQUITY	\$ 904,199	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,302,898	\$	47

*(See instructions.)

Facility Name: The Manor at Mason Woods

Report Period Beginning: 1/1/15

Ending:

12/31/15

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	\$ 1,213,674	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,213,674	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	207	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 207	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	640	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 640	14
D. Other Revenue (specify):			
15	Cable TV Revenue	2,270	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 2,270	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,216,790	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	303,988	19
20	Health Care/ Personal Care	256,880	20
21	General Administration	287,666	21
B. Capital Expense			
22	Ownership	197,661	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)	\$ 1,046,195	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 170,595	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 170,595	31

**The Manor at Mason Woods
2015**

Page 3, Schedule IV, Section D - Other Ownership Expenses

Line	Amount	Description
	504.00	Loan Cost Amortization
	<u>3,123.00</u>	Replacement Tax
22	3,627.00	

Page 3, Schedule IV - Adjustments

Line	Amount	Description
1	(207.00)	Non-allowable meals not directly related to SLF resident care.
3	(2,270.00)	Non-allowable Cable TV expense.
7	(740.00)	Entertainment
21	(4,000.00)	Related Party Lease Expense
22	<u>(3,123.00)</u>	Replacement Tax
	(10,340.00)	

**The Manor at Mason Woods
2015**

VII: RELATED ORGANIZATIONS

A.	RELATED SLF's & HEALTH CARE BUSINESSES			
	<u>Name</u> <u>1</u>	<u>City</u> <u>2</u>		
	Jerseyville Estates	Jerseyville		
	Manor at Craig Farms	Chester		
	Manor at Salem Woods	Salem		

C.	Related Organization	Nature of Expenditure	Facility Book Value	Actual Cost
	Greer Management Services, Inc.	Mgmt Srv/Payroll Srv/Vehicle Lse	\$ 85,294	\$ 93,398

Facility Name: Manor at Mason Woods LP

Report Period Beginning: 1/1/2015

Ending:

12/31/2015

X. INTEREST EXPENSE

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date
		YES	NO			Original	Balance	
		A. Directly Facility Related						
	Long-Term							
1	Murphy-Wall State Bank	X		Mortgage	12/18/09	520,000	411,263	12/18/29
2	PM Properties	X		Mortgage	7/1/12	55,000	42,802	6/30/18
3	Michael Greer	X		Mortgage	7/1/12	55,000	42,802	6/30/18
4	Page Total					630,000	496,867	

8	9	
Interest Rate (4 Digits)	Reporting Period Int. Expense	
6.2500	17,985	1
6.0000	2,691	2
6.0000	2,691	3
	23,367	

**The Manor at Mason Woods
2015**

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Vehicle 1

Model	Grand Caravan
Year	2011
Make	Dodge
Vehicle Use	Resident Transportation

Vehicle 2

Model	Vue
Year	2004
Make	Saturn
Vehicle Use	Resident Transportation

Total Rental Expense	\$4,200
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