

		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><b>I. Facility ID Number:</b> <u>1000094</u></p> <p><b>Facility Name:</b> <u>Tabor Hills Support Lvg Comm</u></p> <p><b>Address:</b> <u>1439 McDowell Road</u> <u>Naperville</u> <u>60563</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>DuPage</u></p> <p><b>Telephone Number:</b> ( <u>630</u> ) <u>778-6677</u> <b>Fax #</b> ( <u>630</u> ) <u>778-6680</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>3/14/08</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" 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><b>IRS Exemption Code</b> <u>501 (c)(3)</u></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 type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Amanda Springborn</u> <b>Telephone Number:</b> ( <u>314</u> ) <u>925-3838</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 (c)(3)</u>	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/2014</u> to <u>9/30/2015</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%;"><b>Officer or Administrator of Provider</b></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><b>Paid Preparer</b></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 &amp; Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) ( <u>847</u> ) <u>517-7070</u> <b>Fax</b> ( <u>847</u> ) <u>517-7067</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 <b>Phone #</b> (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		<b>Paid Preparer</b>	(Signed) _____	(Date) _____		(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> <b>Fax</b> ( <u>847</u> ) <u>517-7067</u>	
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Facility Name Tabor Hills Support Lvg Comm

Report Period Beginning: 10/1/2014 Ending: 9/30/2015

**III. STATISTICAL DATA**

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

Date of change in certified units N/A

	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	87	Single Unit Apartment	87	31,755	1
2	8	Double Unit Apartment	8	2,920	2
3		Other			3
4	95	TOTALS	95	34,675	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	7,524	21,758		29,282	5
6	Double Unit		1,178		1,178	6
7	Other					7
8	TOTALS	7,524	22,936		30,460	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 87.84%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 32 Also, indicate the number of unpaid bed-hold days the SLF had during this year. N/A (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)  
N/A

**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

**I. Is your fiscal year identical to your tax year?**  YES  NO  
Tax Year: 9/30/2015 Fiscal Year: 9/30/2015

\* 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?** No If yes, did the facility make all of the required payments of interest and principle? N/A  
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: Tabor Hills Support Lvg Comm

Report Period Beginning:

10/1/2014

Ending:

9/30/2015

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	218,240	215,557	912	434,709		434,709	1
2	Housekeeping, Laundry and Maintenance	62,949	33,416	83,344	179,709	3,331	183,040	2
3	Heat and Other Utilities			206,188	206,188		206,188	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>281,189</b>	<b>248,973</b>	<b>290,444</b>	<b>820,606</b>	<b>3,331</b>	<b>823,937</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	491,796	26,450	14,991	533,237		533,237	6
7	Activities and Social Services	43,241		5,090	48,331		48,331	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>535,037</b>	<b>26,450</b>	<b>20,081</b>	<b>581,568</b>		<b>581,568</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	234,727		36,262	270,989	(6,976)	264,013	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes	19,158		154,635	173,793		173,793	12
13	Insurance-Property, Liability and Malpractice			21,064	21,064		21,064	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>253,885</b>		<b>211,961</b>	<b>465,846</b>	<b>(6,976)</b>	<b>458,870</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,070,111</b>	<b>275,423</b>	<b>522,486</b>	<b>1,868,020</b>	<b>(3,645)</b>	<b>1,864,375</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			508,360	508,360	453	508,813	17
18	Interest			681,056	681,056	(8,375)	672,681	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>1,189,416</b>	<b>1,189,416</b>	<b>(7,922)</b>	<b>1,181,494</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,070,111</b>	<b>275,423</b>	<b>1,711,902</b>	<b>3,057,436</b>	<b>(11,567)</b>	<b>3,045,869</b>	<b>24</b>

Facility Name: Tabor Hills Support Lvg Comm

Report Period Beginning 10/1/2014

Ending:

9/30/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.01	\$ 39.17	1
2	Licensed Practical Nurses	1.05	26.02	2
3	Certified Nurse Assistants	12.29	13.79	3
4	Activity Director & Assistants	1.37	15.15	4
5	Social Service Workers			5
6	Head Cook	3.88	14.18	6
7	Cook Helpers/Assistants	5.57	8.97	7
8	Dishwashers			8
9	Maintenance Workers	1.02	13.43	9
10	Housekeepers	1.88	8.85	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.66	57.50	13
14	Clerical			14
15	Marketing			15
16	Other Res Serv Coor & HR Dir	1.35	19.76	16
17	<b>Total (lines 1 thru 16)</b>	<b>31.08</b>	<b>\$</b>	<b>17</b>

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			N/A		2
3					3
4					4
5					5
<b>Total</b>				<b>\$</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	N/A	\$ 1
2		2
<b>Total</b>		<b>\$ 3</b>

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
Tabor Hills Health Care Facility, Inc.		Naperville	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Bohemian Home for the Aged		Naperville		Townhomes	

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: Tabor Hills Support Lvg Comm

Report Period Beginning:

10/1/2014

Ending:

9/30/2015

VIII. OWNERSHIP COSTS

A. Purchase price of land 1,049,853 Year land was acquired 2000

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	95		2008	2008	\$ 16,529,128	\$ 415,763	40	\$ 415,763	\$	\$ 3,031,606	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Landscaping		2008	338,303	22,554	15	22,554		164,453	6
7		Landscaping		2009	12,096	302	40	302		1,966	7
8		Oak File Cabinets		2009	4,833	121	40	121		786	8
9		Cable and wire work for new doors		2009	2,500	63	40	63		407	9
10		Exercise room wall, mirror and trim		2009	4,590	115	40	115		746	10
11		Electrical work for spa		2009	3,071	77	40	77		499	11
12		Seeding of west and south basins		2009	4,173	278	15	278		1,808	12
13		Ecological land management		2010	7,837	261	30	261		1,436	13
14		Elevator		2010	5,883	147	40	147		808	14
15		Room 170 Water Leak Repair		2012	8,287	207	40	207		624	15
16		See Attachment 1			172,960	10,313		10,195	(118)	18,634	16
17		TOTAL (lines 1 thru 16)			\$ 17,093,661	\$ 450,200		\$ 450,083	\$ (118)	\$ 3,223,772	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	\$ 697,608	\$ 58,159	\$ 58,730	571	5-10 yrs	\$ 490,781	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 697,608	\$ 58,159	\$ 58,730	571		\$ 490,781	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: Tabor Hills Support Lvg Comm

Report Period Beginning: 10/1/2014

Ending: 9/30/2015

**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			/ /	\$			3
4	Additions	N/A		/ /	N/A			4
5				/ /				5
6				/ /				6
7	<b>TOTAL</b>				\$			7

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

9. Rental amount for movable equipment \$ N/A

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			
	<b>A. Directly Facility Related</b>									
	<b>Long-Term</b>									
1	Illinois Revenue Authority		X	Mortgage	11/22/06	\$ 14,044,982	\$ 11,615,093	11/15/36	Varies	\$ 657,648
2	Bond Financing Expense		X		/ /			/ /		23,408
3					/ /			/ /		
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$ 14,044,982	\$ 11,615,093			\$ 681,056
	<b>B. Non-Facility Related</b>									
8	Interest Income Offset				/ /			/ /		(8,375)
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 14,044,982	\$ 11,615,093			\$ 672,681

\* 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: Tabor Hills Support Lvg Comm

Report Period Beginning: 10/1/2014

Ending:

9/30/2015

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2015

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 12,878	\$ 12,878	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 53,651 )	261,366	261,366	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,533	23,533	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 297,777	\$ 297,777	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,049,853	1,049,853	13
14	Buildings, at Historical Cost	16,541,224	16,541,224	14
15	Leasehold Improvements, at Historical Cost	557,062	552,438	15
16	Equipment, at Historical Cost	699,574	697,608	16
17	Accumulated Depreciation (book methods)	(3,714,321)	(3,714,553)	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 Cost	65,671	65,671	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 15,199,063	\$ 15,192,241	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 15,496,840	\$ 15,490,018	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 3,910	\$ 3,910	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	304,303	304,303	29
30	Accrued Salaries Payable	73,313	73,313	30
31	Accrued Taxes Payable	2	2	31
32	Accrued Interest Payable	266,767	266,767	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	See Schedule 7A	4,311,386	4,311,386	35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 4,959,681	\$ 4,959,681	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable	11,310,790	11,310,790	40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 11,310,790	\$ 11,310,790	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 16,270,471	\$ 16,270,471	45
46	<b>TOTAL EQUITY</b>	\$ (773,631)	\$ (780,453)	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 15,496,840	\$ 15,490,018	47

\*(See instructions.)

Schedule 7A

XI. Balance Sheet

C. Current Liabilities

Line 35: Other current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Due To/Fr Town Home	612,978	612,978
Due To/Fr Nursing Home	3,609,341	3,609,341
Accrued Payables	49,257	49,257
Insurance Payable	8,073	8,073
IDPA Liability	13,693	13,693
SLC Application Processing	15,000	15,000
Pet Deposit Fee	1,000	1,000
Personal Portion FY2008	802	802
Public Aid Credit Balance	1,242	1,242
	<u>4,311,386</u>	<u>4,311,386</u>

Facility Name: Tabor Hills Support Lvg Comm

Report Period Beginning: 10/1/2014

Ending:

9/30/2015

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 3,671,103	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 3,671,103</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
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	13,034	8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 13,034</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions	260	12
13	Interest and Other Investment Income	8,375	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 8,635</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	See Schedule 8A	58,004	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 58,004</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 3,750,776</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	820,606	19
20	Health Care/ Personal Care	581,568	20
21	General Administration	465,846	21
<b>B. Capital Expense</b>			
22	Ownership	1,189,416	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 3,057,436</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 693,340</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 693,340</b>	<b>31</b>

Schedule 8A

XII. Income Statement  
Section D. Other Revenue

<u>Description</u>	<u>Amount</u>
Alarm Pendant	671
Food Stamps	17,269
Pet Deposit	500
Misc Income	2,648
Activities Fundraising	2,221
Internet Private/Per Portion	2,490
Cable Income Private/Per Portion	10,725
Telephone Private/PA	23,280
Food Credit	(1,800)
	<u>58,004</u>

	Improvement Type	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
18	Building Control Systems - Electrical	2013		17,935	1,794	10	1,794	-	4,484
19	Water Heater Installation	2013		8,432	211	40	211	-	527
20	Installation of Call Lights	2013		22,805	2,281	10	2,281	-	5,702
21	Landscaping	2014		12,830	2,566	5	2,566	-	3,849
22	Air Handling Units & VAV Boxes	2014		8,866	400	20	400	-	600
23	Fence Purchase & Installation	2014		4,290	429	10	429	-	644
24	Furnish & Install I/A System of Air Handling	2014		12,500	625	20	625	-	938
25	Landscaping	2015		14,389	480	15	480	-	480
26	Pavement Sealcoat	2015		8,895	635	7	635	-	635
27	Trane Heating Units	2015		4,709	59	40	59	-	59
28	LED Lighting	2015		15,430	193	40	193	-	193
29	LED Light Poles/Junction Box	2015		41,880	524	40	524	-	524
30								-	
31								-	
32								-	
33	Assets under \$2,500 Expensed				118			118	
34								-	
35								-	
36								-	
37								-	
38								-	
39								-	
40								-	
41								-	
42								-	
43								-	
44								-	

45										-	
46	Total (Attachment 1) to Schedule VIII - Line 16			\$ 172,960	\$ 10,313		\$ 10,195		\$ 118	\$ 18,634	