

		FOR BHF USE			

LL2

Supportive Living Facility

**2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)**

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>1000049</u></p> <p>Facility Name: <u>Eden Supportive Living</u></p> <hr/> <p>Address: <u>940 W Gordon Terrace</u> <u>Chicago</u> <u>60613</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 472-1020</u> Fax # <u>(773) 572-4698</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>05/10/05 (Incorporated)</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 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:</p> <p>Name: <u>Mitch Hamblet</u> Telephone Number: <u>(630) 929-3333</u></p> <p>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 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>01/01/18</u> to <u>12/31/18</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%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Michael J. Hamblet, Jr.</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Managing Member</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Paul H. Wieland President</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Wieland & Company, Inc. 201 Houston Street, Ste 301 Batavia, IL 60510</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(630) 406-4490</u> Fax # <u>(630) 406-4491</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>Michael J. Hamblet, Jr.</u>			(Title) <u>Managing Member</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Paul H. Wieland President</u>			(Firm Name & Address) <u>Wieland & Company, Inc. 201 Houston Street, Ste 301 Batavia, IL 60510</u>			(Telephone) <u>(630) 406-4490</u> Fax # <u>(630) 406-4491</u>	
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Facility Name Eden Supportive Living

Report Period Beginning: 01/01/18 Ending: 12/31/18

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	34	Single Unit Apartment	34	12,410	1
2	50	Double Unit Apartment	50	36,500	2
3		Other			3
4	84	TOTALS	84	48,910	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	11,315	1,095		12,410	5
6	Double Unit	30,370	621		30,991	6
7	Other					7
8	TOTALS	41,685	1,716		43,401	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.74%

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

689 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 4820 (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: 12/31/18 Fiscal Year: 12/31/18

* 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 principal? _____
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 principal? _____
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 principal? _____
If no, explain. _____

Facility Name: Eden Supportive Living

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	376,927	313,402		690,329		690,329	1
2	Housekeeping, Laundry and Maintenance	198,183	39,449	103,759	341,391		341,391	2
3	Heat and Other Utilities			157,545	157,545		157,545	3
4	Other (specify):							4
5	TOTAL General Services	575,110	352,851	261,304	1,189,265		1,189,265	5
B. Health Care and Programs								
6	Health Care/ Personal Care	343,439	3,725		347,164		347,164	6
7	Activities and Social Services	75,389		20,190	95,579		95,579	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	418,828	3,725	20,190	442,743		442,743	9
C. General Administration								
10	Administrative and Clerical	358,844	43,478	33,930	436,252		436,252	10
11	Marketing Materials, Promotions and Advertising			12,478	12,478		12,478	11
12	Employee Benefits and Payroll Taxes			202,316	202,316		202,316	12
13	Insurance-Property, Liability and Malpractice			65,315	65,315		65,315	13
14	Other (specify):			988,643	988,643		988,643	14
15	TOTAL General Administration	358,844	43,478	1,302,682	1,705,004		1,705,004	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,352,782	400,054	1,584,176	3,337,012		3,337,012	16
Capital Expenses								
D. Ownership								
17	Depreciation			246,376	246,376		246,376	17
18	Interest			328,725	328,725		328,725	18
19	Real Estate Taxes			105,773	105,773		105,773	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			95,977	95,977		95,977	22
23	TOTAL Ownership			776,851	776,851		776,851	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,352,782	400,054	2,361,027	4,113,863		4,113,863	24

Facility Name: **Eden Supportive Living**

Report Period Beginning: **01/01/18**

Ending: **12/31/18**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 31.25	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	8	12.00	3
4	Activity Director & Assistants	2	16.00	4
5	Social Service Workers			5
6	Head Cook	3	13.00	6
7	Cook Helpers/Assistants	8	12.00	7
8	Dishwashers	3	12.00	8
9	Maintenance Workers	2	13.25	9
10	Housekeepers	3	14.00	10
11	Laundry	1	15.00	11
12	Managers	3	24.35	12
13	Other Administrative	1	40.86	13
14	Clerical	1	12.00	14
15	Marketing	1	21.63	15
16	Other			16
17	Total (lines 1 thru 16)	37	\$ 18.25	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	Affiliate Asset management fees		40	\$ 50,933	1
2					2
3					3
4					4
5					5
				Total	\$ 50933 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	1	City	2
Eden Fox Valley		North Aurora, IL	
Eden Supportive Living Champaign		Champaign, IL	
Eve Assisted Living		Hinsdale, IL	
Eden Supportive Living South Shore		Chicago, IL	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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: Eden Services If yes, what is the value of those services? \$ 50,933

(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: Eden Supportive Living

Report Period Beginning:

01/01/18

Ending:

12/31/18

VIII. OWNERSHIP COSTS

A. Purchase price of land 189,617 Year land was acquired 1999

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	84		1999	2005	\$ 8,039,285	\$ 214,119	40	\$ 214,119	\$	\$ 3,146,413	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Cardio room mirrors		2008	1,850		7			1,850	6
7		Office buildout		2008	4,600	167	28	167		1,823	7
8		Hot water boiler		2009	5,818		7			5,818	8
9		Granite		2009	6,400	233	28	233		2,213	9
10		Hot water boiler		2009	5,818		7			5,818	10
11		Buildout/remodel		2010	7,407	269	28	269		2,264	11
12		Renovations		2011	47,372	1,723	28	1,723		12,205	12
13		Renovations		2012	191,471	6,963	28	6,963		45,259	13
14		Outdoor improvements		2013	8,550	1,221	7	1,221		6,539	14
15		Renovations		2013	2,609	95	28	95		522	15
16		Flagpole		2014	1,922	275	7	275		1,306	16
17		TOTAL (lines 1 thru 16)			\$ 8,323,102	\$ 225,065		\$ 225,065	\$	\$ 3,232,030	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	\$ 347,871	\$ 9,086	\$ 9,086	\$	5 to 7	\$ 313,183	18
19	Vehicles	16,567				5	16,567	19
20	TOTAL (lines 18 and 19)	\$ 364,438	\$ 9,086	\$ 9,086	\$		\$ 329,750	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 & ID Number Eden Supportive Living

#

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 5, Carried Forward		\$ 8,323,102	\$ 225,065		\$ 225,065	\$	\$ 3,232,030	1
2	Tile	2017	2,400	343	7	343		600	2
3	Concrete renovation	2017	9,250	336	28	336		588	3
4	HVAC upgrade	2017	10,675	1,525	7	1,525		2,669	4
5	Sprinkler system update	2017	7,040	1,006	7	1,006		1,593	5
6	Exit signs	2017	11,508	1,644	7	1,644		2,192	6
7	Chimney renovation	2017	20,550	747	28	747		1,058	7
8	Exterior door	2017	3,250	464	7	464		503	8
9	Door	2017	1,990	284	7	284		497	9
10	Automatic door	2017	12,985	1,855	7	1,855		2,628	10
11	Water pumps	2018	13,870	991	7	991		991	11
12	Chiller	2018	17,650	1,051	7	1,051		1,051	12
13	Coils for dining room	2018	11,840	1,691	7	1,691		1,691	13
14	HVAC equipment	2018	12,100	288	7	288		288	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,458,210	\$ 237,290		\$ 237,290	\$	\$ 3,248,379	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name: Eden Supportive Living

Report Period Beginning: 01/01/18

Ending: 12/31/18

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding 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 \$ _____

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**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		Oak Grove Capital		X	Rehab and SLF conversion (REFI)	8/31/11	\$ 9,400,000	\$ 8,249,431	2/21/45	3.8800	\$ 323,275	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 9,400,000	\$ 8,249,431			\$ 323,275	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 9,400,000	\$ 8,249,431			\$ 323,275	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: Eden Supportive Living

Report Period Beginning: 01/01/18

Ending:

12/31/18

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,095,657	\$	1
2	Cash-Patient Deposits	164,665		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>953,000</u>)	1,934,898		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,934		6
7	Other Prepaid Expenses	30,734		7
8	Accounts Receivable (owners or related parties)	15,926		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,284,814	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	189,617		13
14	Buildings, at Historical Cost	8,458,210		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	364,438		16
17	Accumulated Depreciation (book methods)	(3,578,129)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	400,556		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,834,692	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,119,506	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 71,599	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	123,083		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	16,713		30
31	Accrued Taxes Payable	98,300		31
32	Accrued Interest Payable	49,124		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Deferred revenue	26,171		35
36	Current Portion of Mortgage Note	185,598		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 570,588	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,975,761		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Due to Owners (from Surplus Cash)	383,000		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 8,358,761	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,929,349	\$	45
46	TOTAL EQUITY	\$ 1,190,157	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,119,506	\$	47

*(See instructions.)

Facility Name: Eden Supportive Living

Report Period Beginning: 01/01/18

Ending:

12/31/18

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

		1	
I. Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 4,831,619	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,831,619	3
B. Other Operating Revenue			
4	Special Services	182	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		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 182	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	384	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 384	14
D. Other Revenue (specify):			
15	Commercial Rent	12,000	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 12,000	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,844,185	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	1,189,265	19
20	Health Care/ Personal Care	442,743	20
21	General Administration	1,705,004	21
B. Capital Expense			
22	Ownership	776,851	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)	\$ 4,113,863	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 730,322	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 730,322	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 3,411,743	32
33	Private Pay - Net Inpatient Revenue	1,419,876	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 4,831,619	37

ENT 1 PART IV, LINE 14, COLUMN 3 - OTHER GENERAL ADMINISTRATION

expenses	\$ 3,520
accounting fees	10,585
	953,000
eous taxes and licenses	<u>21,538</u>
	<u>\$988,643</u>

ENT 1 PART IV, LINE 22, COLUMN 3 - OTHER OWNERSHIP

insurance premium	\$ 41,656
agement fees	50,933
ion expense	<u>3,388</u>
	<u>\$ 95,977</u>