

		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><b>I. Facility ID Number:</b> <u>1000080</u></p> <p><b>Facility Name:</b> <u>Foxes Grove Supp Living Comm</u></p> <p><b>Address:</b> <u>395 Edwardsville Rd</u> <u>Wood River</u> <u>62095</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Madison</u></p> <p><b>Telephone Number:</b> ( <u>(618) 259-0851</u> Fax # <u>(618) 259-0854</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>7/1/2008</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</td> <td><input checked="" 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>Steven N. Lavenda</u> <b>Telephone Number:</b> <u>(847) 282 - 6300</u>  <b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<input checked="" 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>7/1/2017</u> to <u>6/30/2018</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" style="width:100%"> <tr> <td rowspan="2" style="width:20%; vertical-align: top;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="vertical-align: top;"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Marcum LLP</u> <u>Nine Parkway North, Suite 200 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 282-6300</u> Fax <u>(847) 282-6301</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>	<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>Marcum LLP</u> <u>Nine Parkway North, Suite 200 Deerfield, IL 60015</u>		(Telephone) <u>(847) 282-6300</u> Fax <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name Foxes Grove Supp Living Comm

Report Period Beginning: 7/1/2017 Ending: 6/30/2018

**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	83	Single Unit Apartment	83	30,295	1
2	11	Double Unit Apartment	11	4,015	2
3		Other			3
4	94	TOTALS	94	34,310	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	11,903	11,077		22,980	5
6	Double Unit	1,008	878		1,886	6
7	Other	734	434		1,168	7
8	TOTALS	13,645	12,389		26,034	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 75.88%

**D. Indicate the number of paid bed-hold days the SLF had during this year**  
None Also, indicate the number of unpaid bed-hold days the SLF had during this year. None (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: 6/30/18 Fiscal Year: 6/30/18

\* 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 principle? N/A

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: Foxes Grove Supp Living Comm

Report Period Beginning:

7/1/2017

Ending:

6/30/2018

## 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		175,276	331,848	507,124	(6,383)	500,741	1
2	Housekeeping, Laundry and Maintenance	150,460	23,993	210,360	384,813	(23,773)	361,040	2
3	Heat and Other Utilities			153,947	153,947	311	154,258	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	150,460	199,269	696,155	1,045,884	(29,845)	1,016,039	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	477,841	5,512		483,353	27,645	510,998	6
7	Activities and Social Services	42,477		11,361	53,838		53,838	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	520,318	5,512	11,361	537,191	27,645	564,836	9
<b>C. General Administration</b>								
10	Administrative and Clerical	139,949	5,416	322,694	468,059	(68,121)	399,938	10
11	Marketing Materials, Promotions and Advertising	36,120		9,373	45,493		45,493	11
12	Employee Benefits and Payroll Taxes			152,049	152,049	26,032	178,081	12
13	Insurance-Property, Liability and Malpractice			75,288	75,288	18,308	93,596	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	176,069	5,416	559,404	740,889	(23,781)	717,108	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	846,847	210,197	1,266,920	2,323,964	(25,981)	2,297,983	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			3,493	3,493	171,239	174,732	17
18	Interest			85,619	85,619	324,595	410,214	18
19	Real Estate Taxes					64,610	64,610	19
20	Rent -- Facility and Grounds			846,425	846,425	(832,705)	13,720	20
21	Rent -- Equipment							21
22	Other (specify):					35,527	35,527	22
23	<b>TOTAL Ownership</b>			935,537	935,537	(236,734)	698,803	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	846,847	210,197	2,202,457	3,259,501	(262,716)	2,996,785	24

## Foxes Grove Supp Living Comm

Report Period Beginning: 7/1/2017  
 Ending: 6/30/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Non-Straight Line Depreciation	1,483	17 1
2	Bad Debt - Private	(123,429)	10 2
3	Bank Charges	(2,759)	10 3
4	Meals/Entertainment	(19)	10 4
5	Cable TV	(8,283)	02 5
6	Guest and Employee Meals	(2,850)	01 6
7	Vendor Discount	(3,532)	01 7
8	Misc Other Income	(88)	10 8
9	Interest - Bravo Holding Note	(37,808)	18 9
10	MidCap Line of Credit Fees	(11,857)	18 10
11	Penalties and Fines	(764)	10 11
12	Vendor Late Charges	(107)	10 12
13	Wood River Real Estate - Rental Income	(846,425)	20 13
14	Claims Admin Services - Legal Fees	(956)	10 14
15	Senior Living Services	(31,391)	02 15
16	Bravo Nursing Home Services - Base Fee	(24,000)	10 16
17	Midwest Admin - Base Fee	(36,000)	10 17
18	Midwest Admin - Incentive Fee	(18,523)	10 18
19			19
20	Wood River Real Estate		20
21	Interest Expense - HUD Mortgage	361,938	18 21
22	Interest Expense - HUD MIP	35,527	22 22
23	Real Estate Tax	64,610	19 23
24	Depreciation	162,298	17 24
25	Insurance Expense - Property	13,950	13 25
26			26
27	Bravo Holding Company		27
28	Consulting Fees	11,683	10 28
29	Professional Fees	16,130	10 29
30	Interest	(944)	18 30
31			31
32	Bravo Nursing Home Services, Inc.		32
33	Corporate RN Salaries	27,645	06 33
34	Corporate RN Salaries Benefits	2,812	12 34
35	Administrative Salaries	19,973	10 35
36	Professional Fees	298	10 36
37	Dues & Subscriptions	7	10 37
38	Office Expenses	515	10 38
39	Seminar & Lodging Expense	52	10 39
40	Auto Expense	3,355	10 40
41	Administrative and Office Benefits	1,808	12 41
42			42
43	Claims Administration Services, LLC		43
44	Professional Fees	30	10 44
45	Licenses	7	10 45
46	Legal Salaries	636	10 46
47	Office Expense	31	10 47
48	Seminar	5	10 48
49	Auto Travel Expense	21	10 49
50	Employee Benefits	70	12 50
51			51
52	Midwest Administrative Services, Inc.		52
53	Utilities	209	03 53
54	Maintenance Expense	60	02 54
55	Dues, Subscriptions, Licenses	2,443	10 55
56	Office Salaries	61,446	10 56
57	Office Expenses	15,333	10 57
58	Seminar	132	10 58
59	Travel Expense	5,173	10 59
60	Insurance	3,949	13 60
61	Employee Benefits	19,420	12 61
62	Depreciation	7,359	17 62
63	Interest	13,267	18 63
64	Building Rent	13,720	20 64
65			65
66	Senior Living Services, Inc.		66
67	Utilities	102	03 67
68	Maintenance Salary	13,720	02 68
69	Maintenance Expense	1,442	02 69
70	Maintenance Benefits	1,922	12 70
71	Licenses	10	10 71
72	Office Expense	209	10 72
73	Auto Travel Expense	1,056	10 73
74	Insurance	409	13 74
75	Depreciation	99	17 75
76	Maintenance Supplies	668	02 76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(262,716)	101

Facility Name: Foxes Grove Supp Living Comm

Report Period Beginning: 7/1/2017

Ending:

6/30/2018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.03	\$ 27.27	1
2	Licensed Practical Nurses	4.88	20.53	2
3	Certified Nurse Assistants	9.66	10.51	3
4	Activity Director & Assistants	0.82	9.59	4
5	Social Service Workers	0.83	15.20	5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers	3.08	9.81	9
10	Housekeepers	4.55	9.27	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.95	32.74	13
14	Clerical	0.29	11.26	14
15	Marketing	0.86	20.16	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>27.94</b>	<b>\$ 14.57</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	N/A			\$	1
2					2
3					3
4					4
5					5
				<b>Total</b>	<b>6</b>
				\$	

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	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
See Attachment			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
See Attachment					

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: Foxes Grove Supp Living Comm

Report Period Beginning:

7/1/2017

Ending:

6/30/2018

VIII. OWNERSHIP COSTS

A. Purchase price of land 55,000 Year land was acquired 1987

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	46		1987	1987	\$ 2,252,829	\$ 162,298	40	\$ 56,321	\$ (105,977)	\$ 1,745,945	1
2	48		1990	1990	1,928,599		40	48,215	48,215	1,354,037	2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	Total From Supplemental Page 5's				1,936,930	3,517		49,810	46,293	514,591	6
7											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)				\$ 6,118,358	\$ 165,815		\$ 154,346	\$ (11,469)	\$ 3,614,573	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	\$ 177,639	\$ 2,062	\$ 15,014	12,952		\$ 129,517	18
19	Vehicles	60,878	5,371	5,371			59,243	19
20	TOTAL (lines 18 and 19)	\$ 238,517	\$ 7,433	\$ 20,385	12,952		\$ 188,760	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 &amp; ID Number Foxes Grove Supp Living Comm

Report Period Beginning:

7/1/2017 Ending:

6/30/2018

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Carpet & Vinly For 2 Bedrooms	2011	3,016		20	302	302	2,062	1
2	Carpet & Vinly For 2 Bedrooms	2013	3,755		20	536	536	2,815	2
3	Carpet & Vinly For 3 Bedrooms	2013	4,818		20	688	688	3,499	3
4	Carpet & Vinly For 3 Bedrooms	2014	5,703		20	815	815	3,440	4
5									5
6									6
7									7
8									8
9									9
10									10
11	Wood River Real Estate:								11
12	Various	1990	37,085		25			37,085	12
13	Various	1992	14,250		25	570	570	14,203	13
14	Various	2007	1,699,624		40	42,490	42,490	424,905	14
15	Various	2008	25,239		40	631	631	5,640	15
16	Various	2009	17,760		40	445	445	3,558	16
17	Various	2010	37,071		25-40	993	993	7,060	17
18	Various	2012	37,916		25-40	1,001	1,001	5,089	18
19	Landscaping	2013	3,420		25	137	137	547	19
20	Deck Replacement	2013	23,749		40	593	593	2,536	20
21	New Heating & Cooling Unit	2013	5,090		40	127	127	541	21
22	Hot Water Heater	2013	3,166		40	79	79	330	22
23	Kitchen & Bath Remodel	2013	4,145		40	104	104	389	23
24	Carpet / Vinyl	2013	5,762		40	144	144	516	24
25	Decks	2015	5,240		40	131	131	328	25
26									26
27	Allocated from Senior Living Services, Inc.								27
28	Fire Protection Services	2017	121	24	20	24		48	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,936,930	\$ 24		\$ 49,810	\$ 49,786	\$ 514,591	34

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

Facility Name & ID Number Foxes Grove Supp Living Comm

Report Period Beginning:

7/1/2017 Ending:

6/30/2018

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								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)		\$	\$		\$	\$	34

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

Facility Name & ID Number Foxes Grove Supp Living Comm

Report Period Beginning:

7/1/2017 Ending:

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								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)		\$	\$		\$	\$	34

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

Facility Name: Foxes Grove Supp Living Comm

Report Period Beginning: 7/1/2017

Ending: 6/30/2018

**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			/ /				4
5	Allocated from Midwest Admin Service			/ /	13,720			5
6				/ /				6
7	<b>TOTAL</b>				\$ 13,720			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	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	Berkadia		X	Mortgage	4/1/08	\$ 9,324,500	\$ 8,421,953	5/1/43	0.0565	\$ 361,938	1
2					/ /			/ /			2
3					/ /			/ /			3
	<b>Working Capital</b>										
4	MidCap		X	Line of Credit	8/1/09			12/31/15	0.0500	73,762	4
5	Bravo Holding Note Interest		X		/ /			/ /		-37,808	5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$ 9,324,500	\$ 8,421,953			\$ 397,891	7
	<b>B. Non-Facility Related</b>										
8	Allocated from Midwest Admin Services, Inc				/ /			/ /		13,267	8
9	Allocated from Bravo Holding Company				/ /			/ /		-944	9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 9,324,500	\$ 8,421,953			\$ 410,214	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: **Foxes Grove Supp Living Comm**Report Period Beginning: **7/1/2017**

Ending:

**6/30/2018****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/2018**

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 500	\$ 538	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	504,670	504,670	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		(7,673)	6
7	Other Prepaid Expenses	34,481	34,481	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>See Attached</b>	965,085	965,085	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,504,736	\$ 1,497,101	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		55,000	13
14	Buildings, at Historical Cost		6,038,366	14
15	Leasehold Improvements, at Historical Cost	17,292	79,873	15
16	Equipment, at Historical Cost	26,402	169,152	16
17	Accumulated Depreciation (book methods)	(38,219)	(3,783,403)	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):			22
23	Other(specify): <b>See Attached</b>		213,481	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 5,475	\$ 2,772,469	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,510,211	\$ 4,269,570	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 695,143	\$ 746,727	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,185	45,185	30
31	Accrued Taxes Payable	94,027	176,378	31
32	Accrued Interest Payable		1,361,679	32
33	Deferred Compensation			33
34	Federal and State Income Taxes		26,030	34
	<b>Other Current Liabilities(specify):</b>			
35				35
36	<b>See Attached</b>	2,943,138	567,728	36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 3,777,493	\$ 2,923,727	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable		8,421,953	39
40	Bonds Payable			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>	\$	\$ 8,421,953	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 3,777,493	\$ 11,345,680	45
46	<b>TOTAL EQUITY</b>	\$ (2,267,282)	\$ (7,076,110)	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 1,510,211	\$ 4,269,570	47

\*(See instructions.)

Facility Name: Foxes Grove Supp Living Comm

Report Period Beginning: 7/1/2017

Ending:

6/30/2018

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

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 2,442,193	1
2	Discounts and Allowances	(236)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 2,441,957</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	950	8
9	Non-Resident Meals	2,850	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 3,800</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	37,808	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 37,808</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15		31,855	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 31,855</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 2,515,420</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	1,045,884	19
20	Health Care/ Personal Care	537,191	20
21	General Administration	740,889	21
<b>B. Capital Expense</b>			
22	Ownership	935,537	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>\$ 3,259,501</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (744,081)</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>\$ (744,081)</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 1,346,260	32
33	Private Pay - Net Inpatient Revenue	1,095,697	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 2,441,957</b>	<b>37</b>