

FOR BHF USE					

LL2

**Supportive Living Facility**

**2014  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2014)**

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>100X138</u></p> <p><b>Facility Name:</b> <u>Legacy Memory Support</u></p> <p><b>Address:</b> <u>4755 E Evergreen Crt</u> <u>Decatur</u> <u>62521</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Macon</u></p> <p><b>Telephone Number:</b> ( <u>217</u> ) <u>864-4300</u> <b>Fax #</b> ( )</p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>2012</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 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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Dave Underwood</u> <b>Telephone Number:</b> ( ) _____  <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 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><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>01/01/14</u> to <u>12/31/14</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) _____ (Type or Print Name) <u>David M. Underwood</u> (Title) <u>Executive VP &amp; CFO</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) _____ Fax # ( ) _____</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) _____ (Type or Print Name) <u>David M. Underwood</u> (Title) <u>Executive VP &amp; CFO</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name Legacy Memory Support

Report Period Beginning: 01/01/14 Ending: 12/31/14

**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	20	Single Unit Apartment	20	7,300	1
2		Double Unit Apartment			2
3		Other			3
4	20	TOTALS	20	7,300	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	2,811	4,321		7,132	5
6	Double Unit					6
7	Other					7
8	TOTALS	2,811	4,321		7,132	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.70%

**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. \_\_\_\_\_ **(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: \_\_\_\_\_ 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?** No If yes, did the facility make all of the required payments of interest and principle? \_\_\_\_\_  
 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: Legacy Memory Support

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	42,788	48,877		91,665		91,665	1
2	Housekeeping, Laundry and Maintenance	17,179	9,545		26,724		26,724	2
3	Heat and Other Utilities			32,318	32,318		32,318	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	59,967	58,423	32,318	150,708		150,708	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	121,918	574	2,423	124,916		124,916	6
7	Activities and Social Services	10,765	1,654	29	12,448		12,448	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	132,683	2,228	2,452	137,364		137,364	9
<b>C. General Administration</b>								
10	Administrative and Clerical	40,849	2,924	55,812	99,586	(14,474)	85,112	10
11	Marketing Materials, Promotions and Advertising			13,150	13,150		13,150	11
12	Employee Benefits and Payroll Taxes			54,160	54,160		54,160	12
13	Insurance-Property, Liability and Malpractice			7,268	7,268		7,268	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	40,849	2,924	130,391	174,165	(14,474)	159,690	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	233,499	63,575	165,162	462,236	(14,474)	447,762	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			92,423	92,423		92,423	17
18	Interest			103,840	103,840	(152)	103,688	18
19	Real Estate Taxes			50,874	50,874		50,874	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			2,680	2,680		2,680	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			249,817	249,817	(152)	249,665	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	233,499	63,575	414,978	712,053	(14,626)	697,427	24

Facility Name: Legacy Memory Support

Report Period Beginning 01/01/14

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	3.19	\$ 27.49	1
2	Licensed Practical Nurses	0.47	19.66	2
3	Certified Nurse Assistants	20.16	10.69	3
4	Activity Director & Assistants	1.63	12.58	4
5	Social Service Workers	0.50	15.62	5
6	Head Cook			6
7	Cook Helpers/Assistants	10.90	10.16	7
8	Dishwashers			8
9	Maintenance Workers	0.96	20.98	9
10	Housekeepers	2.78	8.57	10
11	Laundry			11
12	Managers			12
13	Other Administrative	3.79	16.58	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>44.38</b>	<b>\$ 12.58</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					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	Heritage Operations Group LLC	\$ 37,089	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

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: \_\_\_\_\_ 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).

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Report Period Beginning:

01/01/14

Ending:

12/31/14

VIII. OWNERSHIP COSTS

A. Purchase price of land 528,746 Year land was acquired \_\_\_\_\_

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	113				\$ 10,601,024	\$ 35,450		\$ 35,450	\$	\$ 759,966	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6											6
7		Five (5) Eyewash Station Construction		2013	3,392						7
8		Cable TV Installation		2013	22,394						8
9		Final installment - Cable TV		2014	28,210						9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 10,655,020	\$ 35,450		\$ 35,450	\$	\$ 759,966	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	\$ 1,516,743	\$ 56,973	\$ 56,973	\$		\$ 538,016	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 1,516,743	\$ 56,973	\$ 56,973	\$		\$ 538,016	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

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**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: None

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	<b>TOTAL</b>				\$			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	Marine Bank			Mortgage	/ /	\$	11,665,208	/ /		\$ 103,840
2					/ /			/ /		
3					/ /			/ /		
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$	11,665,208			\$ 103,840
	<b>B. Non-Facility Related</b>									
8	Interest				/ /			/ /		-152
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	11,665,208			\$ 103,688

\* 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: Legacy Memory Support

Report Period Beginning: 01/01/14

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## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 675,039	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	462,775		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,934		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Resident Trust</u>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,164,748	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,985,993		13
14	Buildings, at Historical Cost	10,655,021		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,516,743		16
17	Accumulated Depreciation (book methods)	(1,297,982)		17
18	Deferred Charges	43,495		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):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 12,903,270	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 14,068,018	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 98,930	\$	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	178,858		31
32	Accrued Interest Payable	13,852		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 291,640	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,665,208		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>	\$ 11,665,208	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 11,956,848	\$	45
46	<b>TOTAL EQUITY</b>	\$ 2,111,170	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 14,068,018	\$	47

\*(See instructions.)

Facility Name: Legacy Memory Support

Report Period Beginning: 01/01/14

Ending:

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## 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	\$ 928,717	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 928,717</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	2,945	8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 2,945</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	152	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 152</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16	Other	101	16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 101</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 931,916</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	150,708	19
20	Health Care/ Personal Care	137,364	20
21	General Administration	174,165	21
<b>B. Capital Expense</b>			
22	Ownership	249,817	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>\$ 712,053</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 219,863</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>\$ 219,863</b>	<b>31</b>

Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg : Adjustment Line #	Amount
PETTY CASH	675,039				1,009	1,009 PETTY CASH 675,039
CASH IN BANK					1,100	1,100 ACCTS RECEI 553,861
CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR -91,086
ACCOUNTS RECEIVABLE	462,775				1,110	1,110 ACCTS RECEIV-M/C
MEDICARE RECEIVABLES					1,125	1,125 ACCTS RECEIV-IPA
IPA INCOME RECEIVABLE					1,135	1,135 ACCTS RECEIV-IC
MEDICARE COST REPORT					1,140	1,140 UNAPPLIED CASH RECEIPTS
ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID INSU 26,934
A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
PREPAID INSURANCE	26,934				1,310	1,310 SUPPLIES INVENTORY
OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
FOOD INVENTORY					1,409	1,409 LAND 1,985,993
SUPPLIES INVENTORY					1,450	1,450 FURNITURE & 1,516,743
LAND	1,985,993				1,460	-538,016
FURNITURE & EQUIPMENT	1,516,743				1,475	1,475 BUILDING 10,655,021
ACCUM DEPR-FURN & EQUIP	-538,016				1,490	1,490 ACCUM DEPR -759,966
BUILDING & IMPROVEMENT	10,655,021				1,530	1,530 RESIDENT FU 0
ACCUM DEPR-BUILDING	-759,966				1,550	1,550 LOAN FEES 43,495
RESIDENT FUNDS	0				1,551	1,551 LOAN FEES ADDED
LOAN FEES	43,495				1,850	1,850 INTERCOMPA 0
REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUNTS P. -98,930
REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
INTRACOMPANY	0				2,100	2,100 ACCRUED PA 0
ACCOUNTS PAYABLE	-98,930				2,100	2,100 PR CLEARING-BENEFITS
BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
ACCRUED PAYROLL	0				2,110	2,110 ACCRUED PT 0
ACCRUED VACATION PAY	0				2,120	2,120 U.C. TAXES PAYABLE
UC TAXES PAYABLE					2,125	2,125 FICA TAXES F 0
FICA TAX PAYABLE	0	0			2,130	2,130 FEDERAL W/H TAX PAYABLE
FIT PAYABLE					2,140	2,140 STATE W/H TAX PAYABLE
STATE W/H PAYABLE		0			2,152	2,152 WORKERS COMP ACCRUAL
EARNED INCOME CREDIT					2,225	2,225 EMPLOYEEE INSURANCE REFUND

UC FED CREDIT REDUCTION  
PAYROLL SAVINGS

2,230  
2,235

2,230 PAYROLL SAVINGS  
2,240 UNITED FUND





