

		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: 1000149</p> <p>Facility Name: <u>GATEWAY AT RIVER CITY</u></p> <hr/> <p>Address: <u>518 W ROMEO GARRETT</u> <u>PEORIA</u> <u>61605</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>PEORIA</u></p> <p>Telephone Number: (<u>309</u>) <u>673-3115</u> Fax # <u>309 673-3117</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10/27/2016</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input 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 checked="" 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 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: Name: <u>Thomas Staszak</u> Telephone Number: <u>(815) 935-1992</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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>01/01/2018</u> to <u>12/31/2018</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 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>Greg Echols</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO, Gardant Management Solutions</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) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) (<u> </u>) _____</td> <td>Fax # (<u> </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>Greg Echols</u>			(Title) <u>CFO, Gardant Management Solutions</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) (<u> </u>) _____	Fax # (<u> </u>) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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	(Telephone) (<u> </u>) _____	Fax # (<u> </u>) _____																																												

Facility Name GATEWAY AT RIVER CITY

Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	100	Single Unit Apartment	100	36,500	1
2	5	Double Unit Apartment	5	1,825	2
3		Other			3
4	105	TOTALS	105	38,325	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	26,453	753		27,206	5
6	Double Unit					6
7	Other					7
8	TOTALS	26,453	753		27,206	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 70.99%

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

601 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 7 (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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 2018 Fiscal Year: 2018

* 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: GATEWAY AT RIVER CITY

Report Period Beginning:

01/01/2018

Ending: 12/31/2018

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			
A. General Services								
1	Dietary and Food Purchase	218,424	158,236	2,118	378,778		378,778	1
2	Housekeeping, Laundry and Maintenance	87,449	35,193	30,188	152,830		152,830	2
3	Heat and Other Utilities			112,253	112,253	(8,771)	103,482	3
4	Other (specify):			31,238	31,238		31,238	4
5	TOTAL General Services	305,873	193,429	175,797	675,099	(8,771)	666,327	5
B. Health Care and Programs								
6	Health Care/ Personal Care	473,430	17,382		490,812		490,812	6
7	Activities and Social Services	30,446	5,318		35,764		35,764	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	503,876	22,700		526,576		526,576	9
C. General Administration								
10	Administrative and Clerical	220,114	37,274	233,057	490,445	(3,954)	486,491	10
11	Marketing Materials, Promotions and Advertising	66,039	8,279	79,986	154,304		154,304	11
12	Employee Benefits and Payroll Taxes			267,396	267,396		267,396	12
13	Insurance-Property, Liability and Malpractice			50,006	50,006		50,006	13
14	Other (specify):			147,310	147,310	(60,271)	87,039	14
15	TOTAL General Administration	286,153	45,553	777,755	1,109,461	(64,225)	1,045,236	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,095,902	261,682	953,552	2,311,136	(72,997)	2,238,140	16
Capital Expenses								
D. Ownership								
17	Depreciation			690,446	690,446		690,446	
18	Interest			289,573	289,573		289,573	18
19	Real Estate Taxes			91,729	91,729		91,729	
20	Rent -- Facility and Grounds							
21	Rent -- Equipment			8,346	8,346		8,346	
22	Other (specify):			81,668	81,668		81,668	
23	TOTAL Ownership			1,161,762	1,161,762		1,161,762	
24	GRAND TOTAL (Sum of lines 16 and 23)	1,095,902	261,682	2,115,314	3,472,898	(72,997)	3,399,901	24

Facility Name: GATEWAY AT RIVER CITY

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	Inc line 12	\$ Inc line 12	1
2	Licensed Practical Nurses	1	24.62	2
3	Certified Nurse Assistants	13	11.97	3
4	Activity Director & Assistants	Inc line 12	Inc line 12	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	9	10.17	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	2	9.52	10
11	Laundry			11
12	Managers	5	23.78	12
13	Other Administrative	4	22.36	13
14	Clerical	Inc line 13	Inc line 13	14
15	Marketing	Inc line 12	Inc line 12	15
16	Other			16
17	Total (lines 1 thru 16)	33	\$	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

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	Gardant Management Solutions	\$ 129,615	1
2			2
		Total	\$ 129,615 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
_____		_____	
_____		_____	
_____		_____	
_____		_____	

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: _____

(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: GATEWAY AT RIVER CITY

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

VIII. OWNERSHIP COSTS

A. Purchase price of land 1,793,354 Year land was acquired 2015

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	105			2016	\$ 10,406,017	\$ 260,343	40	\$ 260,150	\$ (193)	\$ 578,983	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Leasehold Improvements				1,186,018	59,302	20	59,301	(1)	131,925	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)				\$ 11,592,035	\$ 319,645		\$ 319,451	\$ (194)	\$ 710,908	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	\$ 3,715,746	\$ 370,801	\$ 371,575	774	10	\$ 824,943	18
19					\$		-	19
20	TOTAL (lines 18 and 19)	\$ 3,715,746	\$ 370,801	\$ 371,575	774		\$ 824,943	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	4 Accumulated Depreciation	
21		\$	\$	21
22				22
23				23
24	TOTALS (lines 21, 22 and 23)	\$	\$	24

Facility Name: GATEWAY AT RIVER CITY

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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

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			
	A. Directly Facility Related									
	Long-Term									
1	MERCHANTS CAPITAL CO		X	FIRST MORTGAGE	5/1/15	\$ 9,000,000	\$ 8,774,900	12/1/56	0.0328	\$ 289,573
2										
3										
	Working Capital									
4					/ /			/ /		
5								/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 9,000,000	\$ 8,774,900			\$ 289,573
	B. Non-Facility Related									
8								/ /		
9								/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 9,000,000	\$ 8,774,900			\$ 289,573

* 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: GATEWAY AT RIVER CITY

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 340,224	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (123,069))	528,905		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,569		6
7	Other Prepaid Expenses	2,515		7
8	Accounts Receivable (owners or related parties)	3,028		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 892,242	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,793,354		13
14	Buildings, at Historical Cost	10,406,017		14
15	Leasehold Improvements, at Historical Cost	1,186,018		15
16	Equipment, at Historical Cost	3,715,746		16
17	Accumulated Depreciation (book methods)	(1,535,851)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	141,004		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(28,200)		20
21	Restricted Funds	893,423		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,571,511	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,463,753	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 35,764	\$	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	87,265		31
32	Accrued Interest Payable	24,011		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	1,060,983		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,208,023	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,505,386		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)	\$ 8,505,386	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 9,713,408	\$	45
46	TOTAL EQUITY	\$ 7,750,345	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 17,463,753	\$	47

*(See instructions.)

Facility Name: GATEWAY AT RIVER CITY

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

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	\$ 2,582,869	1
2	Discounts and Allowances	(17,799)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,565,070	3
B. Other Operating Revenue			
4	Special Services	120,249	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	285	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 120,534	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	1,481	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,481	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	4,517	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 4,517	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,691,602	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	675,099	19
20	Health Care/ Personal Care	526,576	20
21	General Administration	1,109,461	21
B. Capital Expense			
22	Ownership	1,161,762	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)	\$ 3,472,898	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (781,296)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (781,296)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 1,723,833	32
33	Private Pay - Net Inpatient Revenue	841,237	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,565,070	37

Operating Expenses PG 3 Other				
A. General Services		D. Ownership		
Other (specify):		Other (specify):		Amt
5200-5000-0-0	Operating Allocation	-	9100-9101-0-0	Interest & Dividend Income
5200-5124-0-0	Exterminating	6,983	9100-9102-0-0	Assessment Income
5200-5127-0-0	Rubbish Removal	9,844	9100-9103-0-0	Assessment Expense
5200-5130-0-0	Vehicle Expense	3,027	9200-9201-1-0	Amortization - Loan Fees
5200-5131-0-0	Transportation Service	1,041	9200-9202-0-0	Financing Fees
5300-5140-0-0	Security & Monitoring	10,342	9200-9203-1-0	Mortgage Interest Premium
	PG3-4.3	31,238	9200-9204-0-0	Mortgage Service Fee
			9200-9205-0-0	Mortgage Insurance Prem
			9200-9206-0-0	Participation Fee
			9200-9207-0-0	Letter of Credit Fee
			9200-9208-0-0	Bond & Draw Fee
			9200-9209-0-0	Remarketing and Trustee Fee
			9200-9210-0-0	Interest Expense-Note
			9200-9211-0-0	Interest Expense-LP
			9200-9212-0-0	Debt Write-Off
			9300-9301-0-0	Partnership Management Fee
			9300-9302-0-0	Asset Management Fee
			9300-9303-0-0	Incentive Management
			9300-9303-1-0	Incentive Asset Mgmt Fee
			9300-9304-0-0	Tax Credit Fees & Incentive Fee
			9300-9305-0-0	Organizational Expense
			9300-9306-0-0	Developer Fees
			9300-9307-0-0	Closing Costs
			9700-9702-0-0	Amortization Expense
			9900-9901-0-0	Prior Period Adjustments
			9900-9902-0-0	Dissolution of Business
			9900-9903-0-0	Loss (Gain) on Sale of Assets
			9900-9904-0-0	Business Interruption
			9900-9905-0-0	Settlement
			9900-9906-0-0	Property Damage Loss
			9900-9907-0-0	Abandonment Loss
			9900-9908-0-0	Grant Income
			9900-9909-0-0	Misc: Title, Recording, Transfer
			PG3-22.3	81,668
C. General Administration				
Other (specify):		Amt		
5160-5060-0-0	Consulting	17,408		
5160-5063-0-0	Legal	11,466		
5160-5064-0-0	Accounting	183		
5160-5066-0-0	Audit	18,360		
5160-5067-0-0	Contract Labor-Serv Prov	-		
5160-5068-0-0	Contract Labor	39,623		
5180-5079-0-0	Bad Debt - Resident	26,619		
5180-5079-1-0	Bad Debt - Resident - Recovery	-		
5180-5080-0-0	Bad Debt - Resident Prior Period	-		
5180-5081-0-0	Bad Debt - Medicaid Pending Denial	33,652		
5180-5081-1-0	Bad Debt - Medicaid Pending - Recovery	-		
5180-5082-0-0	Bad Debt - Medicaid Denial Prior Period	-		
5180-5083-0-0	Bad Debt - Medicaid MCO	-		
5190-5000-0-0	Other Admin Allocation	-		
	PG3-14.3	147,310		
B. Health Care and Programs				
Other (specify):	PG3-8.3			

Operating Expenses - Reclassifications and Adjustments PG 3				
A. General Services				
Heat and Other Utilities				
3300-3303-0-0	Cable			8,771
	PG3-3.5			8,771
C. General Administration				
Administrative and Clerical				
3300-3301-0-0	Beauty Salon & Manicure			-
3300-3304-0-0	Internet Access			1,923
3300-3321-0-0	Telephone- Connection			1,583
3300-3323-0-0	Telephone- Usage			448
5190-5090-0-0	Contributions			-
	PG3-10.5			3,954
C. General Administration				
Other (specify):				
5180-5079-0-0	Bad Debt - Resident			26,619
5180-5079-1-0	Bad Debt - Resident - Recovery			-
5180-5080-0-0	Bad Debt - Resident Prior Period			-
5180-5081-0-0	Bad Debt - Medicaid Pending Denial			33,652
5180-5081-1-0	Bad Debt - Medicaid Pending - Recovery			-
5180-5082-0-0	Bad Debt - Medicaid Denial Prior Period			-
5180-5083-0-0	Bad Debt - Medicaid MCO			-
	PG3-14.5			60,271
D. Ownership				
Interest				
3300-3380-0-0	Interest Income			576
3300-3385-0-0	Interest Income - Reserves			906
	PG3-18.5			1,481
D. Ownership				
Other (specify):				
1302-1007-0-0	A/A - Goodwill			
9200-9209-0-0	Remarketing and Trustee Fee			
	PG3-22.5			-

Balance Sheet PG 7 Other

Balance Sheet

Other Current Assets Detail		Amt
1102-9971-0-0	A/R-Employee Advance	-
1102-9972-0-0	A/R-Gardant Mgmt Solutions	-
1102-9973-0-0	A/R-Insurance Reimbursement	-
1102-9974-0-0	A/R-Subscription Receivable	-
1102-9975-0-0	A/R-CIP	-
1102-9976-0-0	A/R-Other	-
1102-9978-0-0	A/R-TIF/Abatement	-
1105-0009-0-0	Transfer Account	-
1105-0012-0-0	Undeposited Funds	-
PG7-9.1		-

Other Long Term Assets Detail		Amt
1201-0020-0-0	CIP	-
1201-0021-0-0	CIP- Land Option Addition	-
1201-0022-0-0	CIP- Other Addition	-
PG7-23.1		-

Current Liabilities Detail		Amt
2111-0040-0-0	Construction Account Payable	-
2112-0100-0-0	Accrued Asset Management Fee	33,218
2112-0101-0-0	Accrued Partnership Mgmt Fee	-
2112-0102-0-0	Accrued Incentive Mgmt Fee	-
2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
2112-0105-0-0	Accrued Liabilities	26,655
2112-0110-0-0	Accrued Insurance	-
2112-0115-0-0	Accrued Developer Fee	992,640
2112-0130-0-0	Accrued MIP	-
2112-0140-0-0	Accrued Vacation	-
2112-0144-0-0	Payroll Union Dues	-
2112-0146-0-0	Payroll Benefits	-
2112-0150-0-0	Security Deposits	-
2112-0154-0-0	Unclaimed Property	-
2112-0155-0-0	Reservation Deposit	200
2112-0156-0-0	Buy Down Credit	-
2112-0157-0-0	Unapplied Last Month Rent	-
2112-0158-0-0	Deferred Gain on Sale	-
2112-0159-0-0	Unearned Revenue	8,271
2112-0159-1-0	Medicaid Prepayments	-
2112-0159-2-0	Prepaid Medicaid Clearing	-
2112-0159-3-0	Prepaid Rent	-
PG7-35.1		1,060,983

Income Statement PG 8 Other

Income Statement		
Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	4,517
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	-
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-

PG8-15.1

4,517