

		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: 1000111</p> <p>Facility Name: <u>HERITAGE WOODS OF MCLEANSBOR</u></p> <p>Address: <u>605 SOUTH MARSHALL</u> <u>MCLEANSBORO</u> <u>62859</u> <small>Number City Zip Code</small></p> <p>County: <u>HAMILTON</u></p> <p>Telephone Number: (<u>618</u>) <u>643-2908</u> Fax # <u>618 643-2941</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>12/22/2008</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																																												
<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 _____																																													
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>) _____																																												

Facility Name HERITAGE WOODS OF MCLEANSBOR

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	41	Single Unit Apartment	41	14,965	1
2		Double Unit Apartment			2
3		Other			3
4	41	TOTALS	41	14,965	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	7,834	5,385		13,219	5
6	Double Unit					6
7	Other					7
8	TOTALS	7,834	5,385		13,219	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.33%

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

158 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 38 (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: 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? Yes If yes, did the facility make all of the required payments of interest and principle? Yes
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: HERITAGE WOODS OF MCLEANSBOR

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	148,971	77,684	2,084	228,739		228,739	1
2	Housekeeping, Laundry and Maintenance	40,479	15,842	54,200	110,521		110,521	2
3	Heat and Other Utilities			89,483	89,483	(9,916)	79,567	3
4	Other (specify):			20,481	20,481		20,481	4
5	TOTAL General Services	189,450	93,526	166,248	449,224	(9,916)	439,308	5
B. Health Care and Programs								
6	Health Care/ Personal Care	180,806	4,352		185,158		185,158	6
7	Activities and Social Services		3,573		3,573		3,573	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	180,806	7,925		188,731		188,731	9
C. General Administration								
10	Administrative and Clerical	102,328	17,549	137,183	257,060	(16,075)	240,985	10
11	Marketing Materials, Promotions and Advertising	36,653	8,781	18,810	64,244		64,244	11
12	Employee Benefits and Payroll Taxes			157,136	157,136		157,136	12
13	Insurance-Property, Liability and Malpractice			14,867	14,867		14,867	13
14	Other (specify):			43,496	43,496	(2,852)	40,644	14
15	TOTAL General Administration	138,981	26,330	371,492	536,803	(18,927)	517,876	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	509,237	127,781	537,740	1,174,758	(28,843)	1,145,914	16
Capital Expenses								
D. Ownership								
17	Depreciation			140,427	140,427		140,427	17
18	Interest			163,689	163,689	(7,987)	155,702	18
19	Real Estate Taxes			27,564	27,564		27,564	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			8,726	8,726		8,726	21
22	Other (specify):			11,770	11,770		11,770	22
23	TOTAL Ownership			352,176	352,176	(7,987)	344,190	23
24	GRAND TOTAL (Sum of lines 16 and 23)	509,237	127,781	889,916	1,526,934	(36,830)	1,490,104	24

Facility Name: HERITAGE WOODS OF MCLEANSBOR

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	17.28	2
3	Certified Nurse Assistants	7	10.60	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	6	9.85	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	1	8.59	10
11	Laundry			11
12	Managers	3	14.75	12
13	Other Administrative	2	24.54	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)	19	\$	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	\$ 50,483	1
2			2
		Total	\$ 50,483 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: _____ 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: HERITAGE WOODS OF MCLEANSBOR

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

VIII. OWNERSHIP COSTS

A. Purchase price of land 145,000 Year land was acquired 2005

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	41			2008	\$ 4,948,747	\$ 115,471	40	\$ 123,719	\$ 8,248	\$ 1,484,626	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Leasehold Improvements			352,520	15,602	20	17,626	2,024	196,496	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)				\$ 5,301,267	\$ 131,073		\$ 141,345	\$ 10,272	\$ 1,681,122	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	\$ 535,272	\$ 9,354	\$ 59,475	50,121	9	\$ 498,150	18
19					\$		-	19
20	TOTAL (lines 18 and 19)	\$ 535,272	\$ 9,354	\$ 59,475	50,121		\$ 498,150	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: **HERITAGE WOODS OF MCLEANSBOR**

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

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	Peoples National Bank		X	FIRST MORTGAGE	2/28/08	\$ 2,760,000	\$ 2,336,066	9/1/39	0.0600	\$ 143,689
2	IHDA		X	Second Mortgage	2/28/08	2,000,000	2,000,000	9/1/29	0.0100	20,000
3										
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 4,760,000	\$ 4,336,066			\$ 163,689
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 4,760,000	\$ 4,336,066			\$ 163,689

* 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: HERITAGE WOODS OF MCLEANSBOR

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	\$ 48,204	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (49,346))	175,611		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,239		6
7	Other Prepaid Expenses	10,431		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Page 7 Attachment	161		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 251,647	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	145,000		13
14	Buildings, at Historical Cost	4,948,747		14
15	Leasehold Improvements, at Historical Cost	352,520		15
16	Equipment, at Historical Cost	535,272		16
17	Accumulated Depreciation (book methods)	(2,179,272)		17
18	Deferred Charges	1,311		18
19	Organization & Pre-Operating Costs	12,519		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(12,519)		20
21	Restricted Funds	733,503		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,537,081	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,788,728	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 49,328	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	17,574		30
31	Accrued Taxes Payable	28,247		31
32	Accrued Interest Payable	13,736		32
33	Deferred Compensation	174		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	115,644		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 224,704	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,260,882		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)	\$ 4,260,882	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,485,586	\$	45
46	TOTAL EQUITY	\$ 303,141	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,788,728	\$	47

*(See instructions.)

Facility Name: HERITAGE WOODS OF MCLEANSBOR

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	\$ 1,251,708	1
2	Discounts and Allowances	(13,043)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,238,665	3
B. Other Operating Revenue			
4	Special Services	47,353	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	6,833	8
9	Non-Resident Meals	1,238	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 55,424	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	7,987	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 7,987	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	2,948	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 2,948	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,305,024	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	449,224	19
20	Health Care/ Personal Care	188,731	20
21	General Administration	536,803	21
B. Capital Expense			
22	Ownership	352,176	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)	\$ 1,526,934	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (221,910)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (221,910)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 331,723	32
33	Private Pay - Net Inpatient Revenue	906,942	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,238,665	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	9100-9102-0-0	Assessment Income
	1,020		-
5200-5127-0-0	Rubbish Removal	9100-9103-0-0	Assessment Expense
	5,937		-
5200-5130-0-0	Vehicle Expense	9200-9201-1-0	Amortization - Loan Fees
	961		7,519
5200-5131-0-0	Transportation Service	9200-9202-0-0	Financing Fees
	-		-
5300-5140-0-0	Security & Monitoring	9200-9203-1-0	Mortgage Interest Premium
	12,562		-
	PG3-4.3	9200-9204-0-0	Mortgage Service Fee
	20,481		-
		9200-9205-0-0	Mortgage Insurance Prem
			-
C. General Administration		9200-9206-0-0	Participation Fee
Other (specify):	Amt	9200-9207-0-0	Letter of Credit Fee
5160-5060-0-0	Consulting	9200-9208-0-0	Bond & Draw Fee
	923		-
5160-5063-0-0	Legal	9200-9209-0-0	Remarketing and Trustee Fee
	1,975		-
5160-5064-0-0	Accounting	9200-9210-0-0	Interest Expense-Note
	115		-
5160-5066-0-0	Audit	9200-9211-0-0	Interest Expense-LP
	12,204		-
5160-5067-0-0	Contract Labor-Serv Prov	9200-9212-0-0	Debt Write-Off
	-		-
5160-5068-0-0	Contract Labor	9300-9301-0-0	Partnership Management Fee
	25,427		-
5180-5079-0-0	Bad Debt - Resident	9300-9302-0-0	Asset Management Fee
	2,852		3,000
5180-5079-1-0	Bad Debt - Resident - Recovery	9300-9303-0-0	Incentive Management
	-		-
5180-5080-0-0	Bad Debt - Resident Prior Period	9300-9303-1-0	Incentive Asset Mgmt Fee
	-		-
5180-5081-0-0	Bad Debt - Medicaid Pending Denial	9300-9304-0-0	Tax Credit Fees & Incentive Fee
	-		-
5180-5081-1-0	Bad Debt - Medicaid Pending - Recovery	9300-9305-0-0	Organizational Expense
	-		-
5180-5082-0-0	Bad Debt - Medicaid Denial Prior Period	9300-9306-0-0	Developer Fees
	-		-
5180-5083-0-0	Bad Debt - Medicaid MCO	9300-9307-0-0	Closing Costs
	-		-
5190-5000-0-0	Other Admin Allocation	9700-9702-0-0	Amortization Expense
	-		1,251
	PG3-14.3	9900-9901-0-0	Prior Period Adjustments
	43,496		-
		9900-9902-0-0	Dissolution of Business
			-
B. Health Care and Programs		9900-9903-0-0	Loss (Gain) on Sale of Assets
Other (specify):	PG3-8.3	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	11,770

Operating Expenses - Reclassifications and Adjustments PG 3			
A. General Services			
Heat and Other Utilities			
3300-3303-0-0	Cable		9,916
	PG3-3.5		9,916
C. General Administration			
Administrative and Clerical			
3300-3301-0-0	Beauty Salon & Manicure		6,833
3300-3304-0-0	Internet Access		-
3300-3321-0-0	Telephone- Connection		8,272
3300-3323-0-0	Telephone- Usage		400
5190-5090-0-0	Contributions		570
	PG3-10.5		16,075
C. General Administration			
Other (specify):			
5180-5079-0-0	Bad Debt - Resident		2,852
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		-
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		2,852
D. Ownership			
Interest			
3300-3380-0-0	Interest Income		7,756
3300-3385-0-0	Interest Income - Reserves		231
	PG3-18.5		7,987
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	161
1102-9978-0-0	A/R-TIF/Abatement	-
1105-0009-0-0	Transfer Account	-
1105-0012-0-0	Undeposited Funds	-
PG7-9.1		161

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	9,000
2112-0101-0-0	Accrued Partnership Mgmt Fee	-
2112-0102-0-0	Accrued Incentive Mgmt Fee	71,557
2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
2112-0105-0-0	Accrued Liabilities	16,594
2112-0110-0-0	Accrued Insurance	-
2112-0115-0-0	Accrued Developer Fee	-
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	-
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	18,493
2112-0159-1-0	Medicaid Prepayments	-
2112-0159-2-0	Prepaid Medicaid Clearing	-
2112-0159-3-0	Prepaid Rent	-
PG7-35.1		115,644

Income Statement PG 8 Other

Income Statement

Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other (Late fees, NSF fee, Call pendants)	179
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	2,769
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-

PG8-15.1

2,948