

		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: 1000154</p> <p>Facility Name: <u>MONTCLARE SL COMM OF LAWNLE</u></p> <p>Address: <u>4339 W 18TH STREET</u> <u>CHICAGO</u> <u>60623</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: (<u>773</u>) <u>277-0288</u> Fax # <u>773 277-0312</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>6/22/2017</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.</td> <td><input type="checkbox"/> PROPRIETARY Individual</td> <td><input type="checkbox"/> GOVERNMENTAL State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Thomas Staszak</u> Telephone Number: <u>(815) 935-1992</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.	<input type="checkbox"/> PROPRIETARY Individual	<input type="checkbox"/> GOVERNMENTAL State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2018</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) (_____)</td> <td>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>	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) (_____)	Fax # (_____)
<input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.	<input type="checkbox"/> PROPRIETARY Individual	<input type="checkbox"/> GOVERNMENTAL State																																									
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	(Firm Name & Address) _____																																										
	(Telephone) (_____)	Fax # (_____)																																									

Facility Name MONTCLARE SL COMM OF LAWNLE

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	120	Single Unit Apartment	120	43,800	1
2		Double Unit Apartment			2
3		Other			3
4	120	TOTALS	120	43,800	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	21,988	1,997		23,985	5
6	Double Unit					6
7	Other					7
8	TOTALS	21,988	1,997		23,985	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 54.76%

D. Indicate the number of paid bed-hold days the SLF had during this year 812 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 13 (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? 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: MONTCLARE SL COMM OF LAWNDLE

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	187,548	132,579	2,404	322,531		322,531	1
2	Housekeeping, Laundry and Maintenance	77,914	16,686	32,995	127,595		127,595	2
3	Heat and Other Utilities			122,406	122,406	(2,403)	120,003	3
4	Other (specify):			162,855	162,855		162,855	4
5	TOTAL General Services	265,462	149,265	320,660	735,387	(2,403)	732,984	5
B. Health Care and Programs								
6	Health Care/ Personal Care	366,331	11,155		377,486		377,486	6
7	Activities and Social Services	30,324	6,864		37,188		37,188	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	396,655	18,019		414,674		414,674	9
C. General Administration								
10	Administrative and Clerical	180,332	29,813	290,350	500,495	(4,928)	495,567	10
11	Marketing Materials, Promotions and Advertising	136,450	15,333	47,845	199,628		199,628	11
12	Employee Benefits and Payroll Taxes			239,388	239,388		239,388	12
13	Insurance-Property, Liability and Malpractice			61,313	61,313		61,313	13
14	Other (specify):			319,055	319,055	(36,403)	282,652	14
15	TOTAL General Administration	316,782	45,146	957,951	1,319,879	(41,332)	1,278,547	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	978,899	212,430	1,278,611	2,469,940	(43,735)	2,426,205	16
Capital Expenses								
D. Ownership								
17	Depreciation			1,231,070	1,231,070		1,231,070	17
18	Interest			437,375	437,375	(13,095)	424,280	18
19	Real Estate Taxes			127,308	127,308		127,308	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			8,835	8,835		8,835	21
22	Other (specify):			296,830	296,830		296,830	22
23	TOTAL Ownership			2,101,418	2,101,418	(13,095)	2,088,323	23
24	GRAND TOTAL (Sum of lines 16 and 23)	978,899	212,430	3,380,029	4,571,358	(56,830)	4,514,528	24

Facility Name: MONTCLARE SL COMM OF LAWNLE

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	27.31	2
3	Certified Nurse Assistants	8	13.02	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	5	12.24	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	2	11.93	10
11	Laundry			11
12	Managers	5	26.09	12
13	Other Administrative	5	23.02	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)	26	\$	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	\$ 120,878	1
2			2
		Total	\$ 120,878 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: MONTCLARE SL COMM OF LAWNLE

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

VIII. OWNERSHIP COSTS

A. Purchase price of land 138,848 Year land was acquired 2016

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	120			2017	\$ 17,676,122	\$ 440,017	27.5	\$ 642,768	\$ 202,751	\$ 878,147	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Leasehold Improvements				1,763,557	175,421	15	117,570	(57,851)	175,421	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)				\$ 19,439,679	\$ 615,438		\$ 760,339	\$ 144,901	\$ 1,053,568	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	\$ 3,078,142	\$ 615,632	\$ 615,628	(4)	5	\$ 1,225,378	18
19					\$		-	19
20	TOTAL (lines 18 and 19)	\$ 3,078,142	\$ 615,632	\$ 615,628	(4)		\$ 1,225,378	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: **MONTCLARE SL COMM OF LAWNDRY**

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	MIDLAND STATES BANK			Third Mortgage	1/1/16	\$ 12,300,000	\$ 12,101,346	7/1/57	0.0363	\$ 437,375
2	City of Chicago			Fourth Mortgage	1/1/16	3,005,000	2,980,879	12/31/58	none	
3										
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 15,305,000	\$ 15,082,225			\$ 437,375
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 15,305,000	\$ 15,082,225			\$ 437,375

* 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: MONTCLARE SL COMM OF LAWNLE

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	\$ 244,159	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (34,654))	857,707		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,911		6
7	Other Prepaid Expenses	1,332		7
8	Accounts Receivable (owners or related parties)	1,700		8
9	Other(specify): See Page 7 Attachment	798		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,159,608	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	138,848		13
14	Buildings, at Historical Cost	17,676,122		14
15	Leasehold Improvements, at Historical Cost	1,763,557		15
16	Equipment, at Historical Cost	3,078,142		16
17	Accumulated Depreciation (book methods)	(2,278,946)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	89,190		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(8,919)		20
21	Restricted Funds	1,316,286		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,774,280	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 22,933,888	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 511,891	\$	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	117,809		31
32	Accrued Interest Payable	36,607		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	941,212		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,607,519	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	14,507,424		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)	\$ 14,507,424	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 16,114,943	\$	45
46	TOTAL EQUITY	\$ 6,818,945	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 22,933,888	\$	47

*(See instructions.)

Facility Name: MONTCLARE SL COMM OF LAWN DLE

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	\$ 2,537,391	1
2	Discounts and Allowances	(40,647)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,496,744	3
B. Other Operating Revenue			
4	Special Services	39,471	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	598	8
9	Non-Resident Meals	521	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 40,590	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	13,095	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 13,095	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	6,294	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 6,294	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,556,723	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	735,387	19
20	Health Care/ Personal Care	414,674	20
21	General Administration	1,319,879	21
B. Capital Expense			
22	Ownership	2,101,418	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 4,571,358	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (2,014,635)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (2,014,635)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 1,597,789	32
33	Private Pay - Net Inpatient Revenue	898,955	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,496,744	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
	5,410		-
5200-5127-0-0	Rubbish Removal	9100-9103-0-0	Assessment Expense
	6,499		-
5200-5130-0-0	Vehicle Expense	9200-9201-1-0	Amortization - Loan Fees
	31,625		15,076
5200-5131-0-0	Transportation Service	9200-9202-0-0	Financing Fees
	1,656		-
5300-5140-0-0	Security & Monitoring	9200-9203-1-0	Mortgage Interest Premium
	117,665		-
	PG3-4.3		
			162,855
C. General Administration			
Other (specify):	Amt		
5160-5060-0-0	Consulting	9200-9204-0-0	Mortgage Service Fee
	5,584		-
5160-5063-0-0	Legal	9200-9205-0-0	Mortgage Insurance Prem
	3,803		40,754
5160-5064-0-0	Accounting	9200-9206-0-0	Participation Fee
	115		-
5160-5066-0-0	Audit	9200-9207-0-0	Letter of Credit Fee
	20,824		-
5160-5067-0-0	Contract Labor-Serv Prov	9200-9208-0-0	Bond & Draw Fee
	216,300		-
5160-5068-0-0	Contract Labor	9200-9209-0-0	Remarketing and Trustee Fee
	36,026		-
5180-5079-0-0	Bad Debt - Resident	9200-9210-0-0	Interest Expense-Note
	26,920		-
5180-5079-1-0	Bad Debt - Resident - Recovery	9200-9211-0-0	Interest Expense-LP
	-		-
5180-5080-0-0	Bad Debt - Resident Prior Period	9200-9212-0-0	Debt Write-Off
	-		-
5180-5081-0-0	Bad Debt - Medicaid Pending Denial	9300-9301-0-0	Partnership Management Fee
	9,483		216,300
5180-5081-1-0	Bad Debt - Medicaid Pending - Recovery	9300-9302-0-0	Asset Management Fee
	-		12,731
5180-5082-0-0	Bad Debt - Medicaid Denial Prior Period	9300-9303-0-0	Incentive Management
	-		-
5180-5083-0-0	Bad Debt - Medicaid MCO	9300-9303-1-0	Incentive Asset Mgmt Fee
	-		-
5190-5000-0-0	Other Admin Allocation	9300-9304-0-0	Tax Credit Fees & Incentive Fee
	-		3,050
	PG3-14.3	9300-9305-0-0	Organizational Expense
			-
		9300-9306-0-0	Developer Fees
			-
		9300-9307-0-0	Closing Costs
			-
		9700-9702-0-0	Amortization Expense
			8,919
		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
			296,830

Operating Expenses - Reclassifications and Adjustments PG 3	
A. General Services	
Heat and Other Utilities	
3300-3303-0-0	Cable
	2,403
	PG3-3.5
	2,403
C. General Administration	
Administrative and Clerical	
3300-3301-0-0	Beauty Salon & Manicure
	598
3300-3304-0-0	Internet Access
	94
3300-3321-0-0	Telephone- Connection
	2,012
3300-3323-0-0	Telephone- Usage
	-
5190-5090-0-0	Contributions
	2,224
	PG3-10.5
	4,928
C. General Administration	
Other (specify):	
5180-5079-0-0	Bad Debt - Resident
	26,920
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
	9,483
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
	36,403
D. Ownership	
Interest	
3300-3380-0-0	Interest Income
	1,044
3300-3385-0-0	Interest Income - Reserves
	12,051
	PG3-18.5
	13,095
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	798
1102-9978-0-0	A/R-TIF/Abatement	-
1105-0009-0-0	Transfer Account	-
1105-0012-0-0	Undeposited Funds	-
PG7-9.1		798

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	25,091
2112-0101-0-0	Accrued Partnership Mgmt Fee	426,300
2112-0102-0-0	Accrued Incentive Mgmt Fee	-
2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
2112-0105-0-0	Accrued Liabilities	22,879
2112-0110-0-0	Accrued Insurance	-
2112-0115-0-0	Accrued Developer Fee	390,000
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	76,742
2112-0159-1-0	Medicaid Prepayments	-
2112-0159-2-0	Prepaid Medicaid Clearing	-
2112-0159-3-0	Prepaid Rent	-
PG7-35.1		941,212

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 Fees, Call Pendants)	1,007
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	4,725
3300-3393-0-0	Insurance Adjustments	562
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-

PG8-15.1

6,294