

		FOR BHF USE			

LL2

Supportive Living Facility

**2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2020)**

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: <u>1000115</u></p> <p>Facility Name: <u>HERITAGE WOODS BOLINGBROOK</u></p> <p>Address: <u>550 KILDEER</u> <u>BOLINGBROOK</u> <u>60440</u> <small>Number City Zip Code</small></p> <p>County: <u>WILL</u></p> <p>Telephone Number: (<u>630</u>) <u>783-9640</u> Fax # <u>630 783-9648</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>2/27/2009</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>Danel Erickson</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>01/01/2020</u> to <u>12/31/2020</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:30%; vertical-align: top;"> <p>Officer or Administrator of Provider</p> </td> <td> <p>(Signed) _____ (Date) _____</p> <p>(Type or Print Name) <u>Greg Echols</u></p> <p>(Title) <u>CFO, Gardant Management Solutions</u></p> </td> </tr> <tr> <td style="vertical-align: top;"> <p>Paid Preparer</p> </td> <td> <p>(Signed) _____ (Date) _____</p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) (_____) Fax # (_____)</p> </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>	<p>Officer or Administrator of Provider</p>	<p>(Signed) _____ (Date) _____</p> <p>(Type or Print Name) <u>Greg Echols</u></p> <p>(Title) <u>CFO, Gardant Management Solutions</u></p>	<p>Paid Preparer</p>	<p>(Signed) _____ (Date) _____</p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) (_____) Fax # (_____)</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>Officer or Administrator of Provider</p>	<p>(Signed) _____ (Date) _____</p> <p>(Type or Print Name) <u>Greg Echols</u></p> <p>(Title) <u>CFO, Gardant Management Solutions</u></p>																												
<p>Paid Preparer</p>	<p>(Signed) _____ (Date) _____</p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) (_____) Fax # (_____)</p>																												

Facility Name HERITAGE WOODS BOLINGBROOK

Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	105	Single Unit Apartment	105	38,325	1
2	0	Double Unit Apartment	0	0	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	30,965	2,993		33,958	5
6	Double Unit				0	6
7	Other				0	7
8	TOTALS	30,965	2,993	0	33,958	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.61%

D. Indicate the number of paid bed-hold days the SLF had during this year 575 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 6 (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: 2020 Fiscal Year: 2020

* 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: HERITAGE WOODS BOLINGBROOK

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	295,400	210,828	1,401	507,629	0	507,629	1
2	Housekeeping, Laundry and Maintenance	107,223	29,859	73,300	210,382	0	210,382	2
3	Heat and Other Utilities			172,669	172,669	(27,657)	145,012	3
4	Other (specify):	76,316	0	108,619	184,936	0	184,936	4
5	TOTAL General Services	478,939	240,687	355,989	1,075,616	(27,657)	1,047,959	5
B. Health Care and Programs								
6	Health Care/ Personal Care	513,436	21,422	0	534,858	0	534,858	6
7	Activities and Social Services	39,748	9,544	0	49,292	0	49,292	7
8	Other (specify):	0	0	0	0	0	0	8
9	TOTAL Health Care and Programs	553,184	30,966	0	584,150	0	584,150	9
C. General Administration								
10	Administrative and Clerical	232,289	40,823	343,874	616,986	(27,332)	589,654	10
11	Marketing Materials, Promotions and Advertising	58,538	10,494	36,822	105,854	0	105,854	11
12	Employee Benefits and Payroll Taxes	0	0	266,274	266,274	0	266,274	12
13	Insurance-Property, Liability and Malpractice	0	0	67,024	67,024	0	67,024	13
14	Other (specify):	0	0	122,815	122,815	(29,472)	93,343	14
15	TOTAL General Administration	290,827	51,317	836,809	1,178,953	(56,804)	1,122,149	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,322,950	322,970	1,192,799	2,838,719	(84,461)	2,754,258	16
Capital Expenses								
D. Ownership								
17	Depreciation			495,215	495,215	0	495,215	17
18	Interest			390,286	390,286	(3,708)	386,578	18
19	Real Estate Taxes			87,976	87,976	0	87,976	19
20	Rent -- Facility and Grounds			0	0	0	0	20
21	Rent -- Equipment			14,964	14,964	0	14,964	21
22	Other (specify):	0	0	1,527,220	1,527,220	0	1,527,220	22
23	TOTAL Ownership	0	0	2,515,661	2,515,661	(3,708)	2,511,953	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,322,950	322,970	3,708,459	5,354,380	(88,168)	5,266,211	24

Facility Name: HERITAGE WOODS BOLINGBROOK

Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	27.19	2
3	Certified Nurse Assistants	12	14.87	3
4	Activity Director & Assistants	Inc line 12	Inc line 12	4
5	Social Service Workers	0	0.00	5
6	Head Cook	0	0.00	6
7	Cook Helpers/Assistants	9	12.80	7
8	Dishwashers	0	0.00	8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	2	13.52	10
11	Laundry	0	0.00	11
12	Managers	5	28.02	12
13	Other Administrative	5	24.77	13
14	Clerical	Inc line 13	Inc line 13	14
15	Marketing	Inc line 12	Inc line 12	15
16	Other	0	0.00	16
17	Total (lines 1 thru 16)	35	\$	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				\$	0
					6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	Gardant Management Solutions	\$ 258,703	1
2			2
Total		\$ 258,703	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 BOLINGBROOK

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VIII. OWNERSHIP COSTS

A. Purchase price of land 815,542 Year land was acquired 2007

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			2009	\$ 12,529,068	\$ 455,602	27.5	\$ 455,602	\$ 0	\$ 5,425,117	1
2									0		2
3									0		3
4									0		4
5									0		5
Improvement Type											
6	Leasehold Improvements				242,571	16,171	15	16,171	(0)	192,709	6
7									0		7
8									0		8
9									0		9
10									0		10
11									0		11
12									0		12
13									0		13
14									0		14
15									0		15
16									0		16
17	TOTAL (lines 1 thru 16)				\$ 12,771,639	\$ 471,774		\$ 471,774	\$ (0)	\$ 5,617,826	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	\$ 790,905	\$ 23,442	\$ 158,181	134,739	5	\$ 736,232	18
19		0	0	0	\$		-	19
20	TOTAL (lines 18 and 19)	\$ 790,905	\$ 23,442	\$ 158,181	134,739		\$ 736,232	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 BOLINGBROOK

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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	0		\$ 0			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	
		Related**				Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
A. Directly Facility Related											
Long-Term											
1	ORIX Real Estate Capital LLC			FIRST MORTGAGE	3/1/18	11,220,800	10,770,872	4/1/53	0.0358	\$ 388,467	1
2											2
3											3
Working Capital											
4											4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 11,220,800	\$ 10,770,872			\$ 388,467	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 11,220,800	\$ 10,770,872			\$ 388,467	10

* If there is an option to buy the building, please provide complete details on an attached schedule.

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: HERITAGE WOODS BOLINGBROOK

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,101,047	\$	1
2	Cash-Patient Deposits	0		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (115,002))	310,068		3
4	Supply Inventory (priced at)	0		4
5	Short-Term Investments	0		5
6	Prepaid Insurance	39,639		6
7	Other Prepaid Expenses	7,502		7
8	Accounts Receivable (owners or related parties)	9,780		8
9	Other(specify):	0		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,468,036	\$ 0	10
B. Long-Term Assets				
11	Long-Term Notes Receivable	0		11
12	Long-Term Investments	0		12
13	Land	815,542		13
14	Buildings, at Historical Cost	12,529,068		14
15	Leasehold Improvements, at Historical Cost	242,571		15
16	Equipment, at Historical Cost	790,905		16
17	Accumulated Depreciation (book methods)	(6,354,059)		17
18	Deferred Charges	35		18
19	Organization & Pre-Operating Costs	22,927		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(22,927)		20
21	Restricted Funds	908,119		21
22	Other Long-Term Assets (specify):	0		22
23	Other(specify): See Page 7 Attachment	16,400		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,948,582	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,416,618	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 90,338	\$	26
27	Officer's Accounts Payable	0		27
28	Accounts Payable-Patient Deposits	0		28
29	Short-Term Notes Payable	0		29
30	Accrued Salaries Payable	0		30
31	Accrued Taxes Payable	91,244		31
32	Accrued Interest Payable	32,133		32
33	Deferred Compensation	0		33
34	Federal and State Income Taxes	0		34
Other Current Liabilities(specify):				
35	See Page 7 Attachment	1,775,163		35
36		0		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,988,878	\$ 0	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable	0		38
39	Mortgage Payable	10,569,494		39
40	Bonds Payable	0		40
41	Deferred Compensation	0		41
Other Long-Term Liabilities(specify):				
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 10,569,494	\$ 0	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 12,558,373	\$ 0	45
46	TOTAL EQUITY	\$ (1,141,755)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 11,416,618	\$ 0	47

*(See instructions.)

Facility Name: HERITAGE WOODS BOLINGBROOK

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

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	\$ 4,359,390	1
2	Discounts and Allowances	(15,727)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,343,663	3
B. Other Operating Revenue			
4	Special Services	179,244	4
5	Other Health Care Services	0	5
6	Special Grants	708,572	6
7	Gift and Coffee Shop	0	7
8	Barber and Beauty Care	1,389	8
9	Non-Resident Meals	100	9
10	Laundry	0	10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 889,305	11
C. Non-Operating Revenue			
12	Contributions	0	12
13	Interest and Other Investment Income	3,708	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 3,708	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	3,643	15
16		0	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 3,643	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 5,240,319	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	1,075,616	19
20	Health Care/ Personal Care	584,150	20
21	General Administration	1,178,953	21
B. Capital Expense			
22	Ownership	2,515,661	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)	\$ 5,354,380	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (114,061)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (114,061)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 2,503,224	32
33	Private Pay - Net Inpatient Revenue	1,840,439	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 4,343,663	37

Operating Expenses PG 3 Other			
A. General Services		D. Ownership	
Labor Other (specify):		Other (specify):	
9900-9001-0-0	Extraordinary COVID Labor	76,316	
9900-9001-0-2	Extraordinary COVID - Labor	-	
	PG3-4.1	76,316	
A. General Services		D. Ownership	
Other (specify):		Amt	
5200-5000-0-0	Operating Allocation	152,633	
5200-5124-0-0	Exterminating	2,031	
5200-5127-0-0	Rubbish Removal	1,288	
5200-5130-0-0	Vehicle Expense	3,218	
5200-5131-0-0	Transportation Service	104	
5300-5140-0-0	Security & Monitoring	21,024	
9900-9002-0-0	Extraordinary COVID - Supplies & Equipment	78,019	
9900-9003-0-0	Extraordinary COVID - Other	2,935	
	PG3-4.3	108,619	
C. General Administration		D. Ownership	
Other (specify):		Amt	
5160-5060-0-0	Consulting	19,960	
5160-5063-0-0	Legal	21,778	
5160-5064-0-0	Accounting	225	
5160-5066-0-0	Audit	17,105	
5160-5067-0-0	Contract Labor-Serv Prov	-	
5160-5068-0-0	Contract Labor	34,275	
5180-5079-0-0	Bad Debt - Resident	303,941	
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	31,873	
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	15,969	
5190-5000-0-0	Other Admin Allocation	-	
	PG3-14.3	122,815	
			PG3-22.3
			1,527,220

Operating Expenses - Reclassifications and Adjustments PG 3			
A. General Services		D. Ownership	
Heat and Other Utilities		Interest	
3300-3303-0-0	Cable	27,657	
	PG3-3.5	27,657	
C. General Administration		D. Ownership	
Administrative and Clerical		Interest	
3300-3301-0-0	Beauty Salon & Manicure	1,389	
3300-3304-0-0	Internet Access	4,026	
3300-3321-0-0	Telephone- Connection	16,829	
3300-3323-0-0	Telephone- Usage	88	
5190-5090-0-0	Contributions	5,000	
	PG3-10.5	27,332	
C. General Administration		D. Ownership	
Other (specify):		Interest	
5180-5079-0-0	Bad Debt - Resident	(18,370)	
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	31,873	
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	15,969	
	PG3-14.5	29,472	
D. Ownership		D. Ownership	
Interest		Interest	
3300-3380-0-0	Interest Income	3,120	
3300-3385-0-0	Interest Income - Reserves	587	
	PG3-18.5	3,708	
D. Ownership		D. Ownership	
Other (specify):		Interest	
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		
1201-0020-0-0	CIP	-
1201-0021-0-0	CIP- Land Option Addition	16,400
1201-0022-0-0	CIP- Other Addition	-
PG7-23.1		16,400.00

Current Liabilities Detail		Amt
2111-0040-0-0	Construction Account Payable	-
2112-0100-0-0	Accrued Asset Management Fee	20,764
2112-0101-0-0	Accrued Partnership Mgmt Fee	-
2112-0102-0-0	Accrued Incentive Mgmt Fee	1,403,897
2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	45,423
2112-0105-0-0	Accrued Liabilities	47,060
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	45,531
2112-0159-1-0	Medicaid Prepayments	212,489
2112-0159-2-0	Prepaid Medicaid Clearing	-
2112-0159-3-0	Prepaid Rent	-
PG7-35.1		1,775,163

Income Statement PG 8 Other

Income Statement		
Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	43 Returned check charges
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	3,600
3300-3393-0-0	Insurance Adjustments	-
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
3300-3202-0-0	Food & Meal Prep	-

PG8-15.1

3,643