

		FOR BHF USE			

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**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><b>I. Facility ID Number:</b> <u>1000145</u></p> <p><b>Facility Name:</b> <u>ST ANTHONY OF LANSING</u></p> <p><b>Address:</b> <u>3025 SPRING LAKE DR</u> <u>LANSING</u> <u>60438</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>( 708 ) 474-6100</u> Fax # <u>708 474-6102</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>6/17/2009</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Danel Erickson</u> <b>Telephone Number:</b> <u>(815) 935-1992</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</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%; border: none;"> <tr> <td style="width:20%; border: none; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td style="border: none;">           (Signed) _____            (Type or Print Name) <u>Greg Echols</u>            (Title) <u>CFO, Gardant Management Solutions</u> </td> </tr> <tr> <td style="border: none; vertical-align: top;"> <b>Paid Preparer</b> </td> <td style="border: none;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) <u>( )</u> Fax # <u>( )</u> </td> </tr> </table> <p align="right"> <b>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</b> </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Greg Echols</u> (Title) <u>CFO, Gardant Management Solutions</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Greg Echols</u> (Title) <u>CFO, Gardant Management Solutions</u>							
<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>							

Facility Name ST ANTHONY OF LANSING

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	125	Single Unit Apartment	125	45,625	1
2	0	Double Unit Apartment	0	0	2
3		Other			3
4	125	TOTALS	125	45,625	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	38,753	1,738		40,491	5
6	Double Unit				0	6
7	Other				0	7
8	TOTALS	38,753	1,738	0	40,491	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.75%

D. Indicate the number of paid bed-hold days the SLF had during this year 921 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 145 (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)

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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: ST ANTHONY OF LANSING

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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	302,040	265,565	1,592	569,197	0	569,197	1
2	Housekeeping, Laundry and Maintenance	180,938	58,119	38,878	277,935	0	277,935	2
3	Heat and Other Utilities			147,912	147,912	(27,605)	120,308	3
4	Other (specify):	88,271	0	133,490	221,762	0	221,762	4
5	<b>TOTAL General Services</b>	571,249	323,684	321,872	1,216,806	(27,605)	1,189,201	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	771,510	22,530	0	794,040	0	794,040	6
7	Activities and Social Services	39,869	9,179	0	49,048	0	49,048	7
8	Other (specify):	0	0	0	0	0	0	8
9	<b>TOTAL Health Care and Programs</b>	811,379	31,709	0	843,088	0	843,088	9
<b>C. General Administration</b>								
10	Administrative and Clerical	253,006	68,666	373,712	695,384	(25,237)	670,147	10
11	Marketing Materials, Promotions and Advertising	69,315	14,680	61,384	145,379	0	145,379	11
12	Employee Benefits and Payroll Taxes	0	0	368,355	368,355	0	368,355	12
13	Insurance-Property, Liability and Malpractice	0	0	124,770	124,770	0	124,770	13
14	Other (specify):	0	0	356,025	356,025	(239,490)	116,534	14
15	<b>TOTAL General Administration</b>	322,321	83,346	1,284,246	1,689,913	(264,728)	1,425,185	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	1,704,949	438,739	1,606,118	3,749,806	(292,332)	3,457,474	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			603,227	603,227	0	603,227	17
18	Interest			1,180,400	1,180,400	(14,896)	1,165,504	18
19	Real Estate Taxes			270,564	270,564	0	270,564	19
20	Rent -- Facility and Grounds			0	0	0	0	20
21	Rent -- Equipment			15,395	15,395	0	15,395	21
22	Other (specify):	0	0	620,037	620,037	(3,957)	616,080	22
23	<b>TOTAL Ownership</b>	0	0	2,689,623	2,689,623	(18,852)	2,670,771	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	1,704,949	438,739	4,295,741	6,439,429	(311,184)	6,128,245	24

Facility Name: ST ANTHONY OF LANSING

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	2	26.86	2
3	Certified Nurse Assistants	19	15.21	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	10	13.69	7
8	Dishwashers	0	0.00	8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	13.93	10
11	Laundry	0	0.00	11
12	Managers	6	25.69	12
13	Other Administrative	6	23.76	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	<b>Total (lines 1 thru 16)</b>	<b>46</b>	<b>\$</b>	<b>17</b>

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1				\$	1
2					2
3					3
4					4
5					5
<b>Total</b>				<b>\$</b>	<b>0</b>

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	Gardant Management Solutions	\$ 310,737	1
2			2
<b>Total</b>		<b>\$ 310,737</b>	<b>3</b>

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name 1	City 2
DEER PATH SLF, LLC	HUNTLEY

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: ST ANTHONY OF LANSING

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VIII. OWNERSHIP COSTS

A. Purchase price of land 2,558,268 Year land was acquired 2012

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	125			2013	\$ 17,638,210	\$ 440,796	40	\$ 440,955	\$ 160	\$ 3,246,476	1
2									0		2
3									0		3
4									0		4
5									0		5
<b>Improvement Type</b>											
6	Leasehold Improvements				327,005	16,350	20	16,350	0	120,454	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)				\$ 17,965,215	\$ 457,146		\$ 457,306	\$ 160	\$ 3,366,931	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 1,467,334	\$ 146,082	\$ 146,733	651	10	\$ 1,053,622	18
19		0	0	0			-	19
20	TOTAL (lines 18 and 19)	\$ 1,467,334	\$ 146,082	\$ 146,733	651		\$ 1,053,622	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: ST ANTHONY OF LANSING

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	<b>TOTAL</b>		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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		<b>A. Directly Facility Related</b>										
		<b>Long-Term</b>										
1		AMALGAMATED BANK		X	FIRST MORTGAGE	7/13/12	\$ 18,630,000	\$ 18,025,000	12/1/32	0.0650	\$ 1,180,400	1
2		COUNTY OF COOK			Second Mortgage	7/12/12	3,000,000	3,000,000	7/12/54	none		2
3		0			0	1/0/00	0	0	1/0/00	0.0000		3
		<b>Working Capital</b>										
4						/ /		0	/ /		0	4
5						/ /			/ /			5
6						/ /			/ /			6
7		<b>TOTAL Facility Related</b>					\$ 21,630,000	\$ 21,025,000			\$ 1,180,400	7
		<b>B. Non-Facility Related</b>										
8						/ /			/ /			8
9						/ /			/ /			9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 21,630,000	\$ 21,025,000			\$ 1,180,400	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: ST ANTHONY OF LANSING

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 234,249	\$	1
2	Cash-Patient Deposits	14,140		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (277,412) )	0		3
4	Supply Inventory (priced at )	463,721		4
5	Short-Term Investments	0		5
6	Prepaid Insurance	0		6
7	Other Prepaid Expenses	46,907		7
8	Accounts Receivable (owners or related parties)	125,117		8
9	Other(specify):	0		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 884,135	\$ 0	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable	0		11
12	Long-Term Investments	0		12
13	Land	2,558,268		13
14	Buildings, at Historical Cost	17,638,210		14
15	Leasehold Improvements, at Historical Cost	327,005		15
16	Equipment, at Historical Cost	1,467,334		16
17	Accumulated Depreciation (book methods)	(4,420,552)		17
18	Deferred Charges	590		18
19	Organization & Pre-Operating Costs	1,000,212		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0		20
21	Restricted Funds	(319,073)		21
22	Other Long-Term Assets (specify):	2,865,756		22
23	Other(specify):	0		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 21,117,750	\$ 0	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 22,001,885	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 278,963	\$	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	273,464		31
32	Accrued Interest Payable	99,071		32
33	Deferred Compensation	0		33
34	Federal and State Income Taxes	0		34
	<b>Other Current Liabilities(specify):</b>			
35	See Page 7 Attachment	801,508		35
36		0		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 1,453,007	\$ 0	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	0		38
39	Mortgage Payable	20,363,561		39
40	Bonds Payable	0		40
41	Deferred Compensation	0		41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 20,363,561	\$ 0	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 21,816,568	\$ 0	45
46	<b>TOTAL EQUITY</b>	\$ 185,317	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 22,001,885	\$ 0	47

\*(See instructions.)

Facility Name: ST ANTHONY OF LANSING

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	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 5,220,289	1
2	Discounts and Allowances	(20,967)	2
<b>SUBTOTAL Resident Care</b>			
3	(line 1 minus line 2)	\$ 5,199,322	3
<b>B. Other Operating Revenue</b>			
4	Special Services	235,735	4
5	Other Health Care Services	0	5
6	Special Grants	819,432	6
7	Gift and Coffee Shop	0	7
8	Barber and Beauty Care	1,000	8
9	Non-Resident Meals	0	9
10	Laundry	0	10
<b>SUBTOTAL OTHER OPERATING REVENUE</b>			
11	(sum of lines 4 thru 10)	\$ 1,056,167	11
<b>C. Non-Operating Revenue</b>			
12	Contributions	0	12
13	Interest and Other Investment Income	14,896	13
<b>SUBTOTAL Non-Operating Revenue</b>			
14	(sum of lines 12 and 13)	\$ 14,896	14
<b>D. Other Revenue (specify):</b>			
15	See Page 8 Attachment	50,022	15
16		0	16
<b>SUBTOTAL Other Revenue</b>			
17	(sum of lines 15 and 16)	\$ 50,022	17
<b>TOTAL REVENUE</b>			
18	(sum of lines 3, 11, 14 and 17)	\$ 6,320,407	18

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	1,216,806	19
20	Health Care/ Personal Care	843,088	20
21	General Administration	1,689,913	21
<b>B. Capital Expense</b>			
22	Ownership	2,689,623	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
<b>TOTAL EXPENSES</b>			
28	(sum of lines 19 thru 27)	\$ 6,439,429	28
<b>Income Before Income Taxes</b>			
29	(line 18 minus line 28)	\$ (119,022)	29
<b>Income Taxes</b>			
30		\$	30
<b>NET INCOME OR LOSS FOR THE YEAR</b>			
31	(line 29 minus line 30)	\$ (119,022)	31
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 3,482,806	32
33	Private Pay - Net Inpatient Revenue	1,716,516	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 5,199,322	37



Operating Expenses PG 3 Other			
<b>A. General Services</b>		<b>D. Ownership</b>	
Labor Other (specify):		Other (specify):	
9900-9001-0-0	Extraordinary COVID Labor	88,271	
9900-9001-0-2	Extraordinary COVID - Labor	-	
	<b>PG3-4.1</b>	88,271	
<b>A. General Services</b>		<b>D. Ownership</b>	
Other (specify):		Amt	
5200-5000-0-0	Operating Allocation	176,543	
5200-5124-0-0	Exterminating	4,422	
5200-5127-0-0	Rubbish Removal	37,254	
5200-5130-0-0	Vehicle Expense	2,342	
5200-5131-0-0	Transportation Service	711	
5300-5140-0-0	Security & Monitoring	9,138	
9900-9002-0-0	Extraordinary COVID - Supplies & Equipment	76,769	
9900-9003-0-0	Extraordinary COVID - Other	2,854	
	<b>PG3-4.3</b>	<b>133,490</b>	
<b>C. General Administration</b>		<b>D. Ownership</b>	
Other (specify):		Amt	
5160-5060-0-0	Consulting	5,069	
5160-5063-0-0	Legal	51,343	
5160-5064-0-0	Accounting	185	
5160-5066-0-0	Audit	13,672	
5160-5067-0-0	Contract Labor-Serv Prov	-	
5160-5068-0-0	Contract Labor	46,265	
5180-5079-0-0	Bad Debt - Resident	338,786	
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	55,967	
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	14,119	
5190-5000-0-0	Other Admin Allocation	-	
	<b>PG3-14.3</b>	<b>356,025</b>	
			<b>620,037</b>

Operating Expenses - Reclassifications and Adjustments PG 3			
<b>A. General Services</b>		<b>D. Ownership</b>	
Heat and Other Utilities		Interest	
3300-3303-0-0	Cable	27,605	
	<b>PG3-3.5</b>	<b>27,605</b>	
<b>C. General Administration</b>		<b>D. Ownership</b>	
Administrative and Clerical		Interest Income	
3300-3301-0-0	Beauty Salon & Manicure	1,000	
3300-3304-0-0	Internet Access	205	
3300-3321-0-0	Telephone- Connection	15,618	
3300-3323-0-0	Telephone- Usage	3,415	
5190-5090-0-0	Contributions	5,000	
	<b>PG3-10.5</b>	<b>25,237</b>	
<b>C. General Administration</b>		<b>D. Ownership</b>	
Other (specify):		Interest	
5180-5079-0-0	Bad Debt - Resident	169,405	
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	55,967	
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	14,119	
	<b>PG3-14.5</b>	<b>239,490</b>	
<b>D. Ownership</b>		<b>D. Ownership</b>	
Interest		Interest Income - Reserves	
3300-3380-0-0	Interest Income	8,591	
3300-3385-0-0	Interest Income - Reserves	6,305	
	<b>PG3-18.5</b>	<b>14,896</b>	
<b>D. Ownership</b>		<b>D. Ownership</b>	
Other (specify):		A/A - Goodwill	
1302-1007-0-0	A/A - Goodwill	-	
9200-9209-0-0	Remarketing and Trustee Fee	3,957	
	<b>PG3-22.5</b>	<b>3,957</b>	

**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	-
<b>PG7-9.1</b>		<b>-</b>

Other Long Term Assets Detail		
1201-0020-0-0	CIP	-
1201-0021-0-0	CIP- Land Option Addition	-
1201-0022-0-0	CIP- Other Addition	-
<b>PG7-23.1</b>		<b>-</b>

Current Liabilities Detail		Amt
2111-0040-0-0	Construction Account Payable	-
2112-0100-0-0	Accrued Asset Management Fee	10,000
2112-0101-0-0	Accrued Partnership Mgmt Fee	-
2112-0102-0-0	Accrued Incentive Mgmt Fee	476,811
2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
2112-0105-0-0	Accrued Liabilities	33,322
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	4,547
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	40,113
2112-0159-1-0	Medicaid Prepayments	236,714
2112-0159-2-0	Prepaid Medicaid Clearing	-
2112-0159-3-0	Prepaid Rent	-
<b>PG7-35.1</b>		<b>801,508</b>

## Income Statement PG 8 Other

Income Statement		
Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	2,785 Late Fees, NSF's, Key replacements
3300-3391-0-0	Property Tax Adjustments	47,237
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	-
3300-3202-0-0	Food & Meal Prep	-

**PG8-15.1**

**50,022**