

		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.

I. Facility ID Number: 1000031 Facility Name: CAMBRIDGE HOUSE OF OFALLON Address: 844 CAMBRIDGE BLVD OFALLON 62269 County: ST CLAIR Telephone Number: (618) 624-9900 Fax # 618 624-9904 Federal Employer ID Number: Date Current Owners were Certified: 4/16/2004 Type of Ownership: <table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☒ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code</td><td>☐ Corporation</td><td>☐ Other</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other</td><td></td></tr></table> In the event there are further questions about this report, please contact: Name: Danel Erickson Telephone Number: (815) 935-1992 Email Address:	☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☒ Partnership	☐ County	IRS Exemption Code	☐ Corporation	☐ Other		☐ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. <table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed)</td><td></td><td>(Date)</td></tr><tr><td>(Type or Print Name)</td><td colspan="2">Greg Echols</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Title)</td><td colspan="2">CFO, Gardant Management Solutions</td></tr><tr><td>(Signed)</td><td></td><td>(Date)</td></tr><tr><td>(Print Name and Title)</td><td colspan="2"></td></tr><tr><td>(Firm Name & Address)</td><td colspan="2"></td></tr><tr><td>(Telephone)</td><td>()</td><td>Fax # ()</td></tr></table> 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	Officer or Administrator of Provider	(Signed)		(Date)	(Type or Print Name)	Greg Echols		Paid Preparer	(Title)	CFO, Gardant Management Solutions		(Signed)		(Date)	(Print Name and Title)			(Firm Name & Address)			(Telephone)	()	Fax # ()
☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																																														
☐ Charitable Corp.	☐ Individual	☐ State																																														
☐ Trust	☒ Partnership	☐ County																																														
IRS Exemption Code	☐ Corporation	☐ Other																																														
	☐ "Sub-S" Corp.																																															
	☐ Limited Liability Co.																																															
	☐ Trust																																															
	☐ Other																																															
Officer or Administrator of Provider	(Signed)		(Date)																																													
	(Type or Print Name)	Greg Echols																																														
Paid Preparer	(Title)	CFO, Gardant Management Solutions																																														
	(Signed)		(Date)																																													
	(Print Name and Title)																																															
	(Firm Name & Address)																																															
	(Telephone)	()	Fax # ()																																													

Facility Name CAMBRIDGE HOUSE OF OFALLON

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	100	Single Unit Apartment	100	36,500	1
2	3	Double Unit Apartment	3	1,095	2
3		Other			3
4	103	TOTALS	103	37,595	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	26,886	7,025		33,911	5
6	Double Unit				0	6
7	Other				0	7
8	TOTALS	26,886	7,025	0	33,911	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.20 %

D. Indicate the number of paid bed-hold days the SLF had during this year 559 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 111 (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 X

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO X

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? X 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.

STATE OF ILLINOIS

Page 3

Facility Name: CAMBRIDGE HOUSE OF OFALLON

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	323,861	227,877	949	552,687	0	552,687	1
2	Housekeeping, Laundry and Maintenance	114,493	46,249	33,581	194,323	0	194,323	2
3	Heat and Other Utilities			152,722	152,722	(22,604)	130,118	3
4	Other (specify):	59,705	0	75,057	134,762	0	134,762	4
5	TOTAL General Services	498,059	274,126	262,309	1,034,494	(22,604)	1,011,890	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	547,743	18,049	0	565,792	0	565,792	6
7	Activities and Social Services	41,308	6,021	0	47,329	0	47,329	7
8	Other (specify):	0	0	0	0	0	0	8
9	TOTAL Health Care and Programs	589,051	24,070	0	613,121	0	613,121	9
	C. General Administration							
10	Administrative and Clerical	199,626	57,894	381,268	638,788	(19,892)	618,896	10
11	Marketing Materials, Promotions and Advertising	64,908	16,979	48,720	130,607	0	130,607	11
12	Employee Benefits and Payroll Taxes	0	0	293,409	293,409	0	293,409	12
13	Insurance-Property, Liability and Malpractice	0	0	87,787	87,787	0	87,787	13
14	Other (specify):	0	0	73,573	73,573	(13,454)	60,119	14
15	TOTAL General Administration	264,534	74,873	884,757	1,224,164	(33,346)	1,190,817	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,351,644	373,069	1,147,065	2,871,778	(55,950)	2,815,828	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			325,817	325,817	0	325,817	17
18	Interest			310,817	310,817	(19,274)	291,543	18
19	Real Estate Taxes			68,646	68,646	0	68,646	19
20	Rent -- Facility and Grounds			0	0	0	0	20
21	Rent -- Equipment			16,524	16,524	0	16,524	21
22	Other (specify):	0	0	1,263,975	1,263,975	0	1,263,975	22
23	TOTAL Ownership	0	0	1,985,779	1,985,779	(19,274)	1,966,505	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,351,644	373,069	3,132,845	4,857,558	(75,224)	4,782,333	24

Facility Name: CAMBRIDGE HOUSE OF OFALLON

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	26.23	2
3	Certified Nurse Assistants	15	13.70	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	11	12.52	7
8	Dishwashers	0	0.00	8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	10.99	10
11	Laundry	0	0.00	11
12	Managers	5	26.31	12
13	Other Administrative	4	26.89	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)	39	\$	17

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
CAMBRIDGE HOUSE OF MARYVILLE	MARYVILLE
CAMBRIDGE HOUSE OF SWANSEA	SWANSEA

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? \$

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).

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	\$ 292,029	1
2			2
Total		\$ 292,029	3

Facility Name: CAMBRIDGE HOUSE OF OFALLON Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VIII. OWNERSHIP COSTS

A. Purchase price of land 1,028,000 Year land was acquired 2002

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	103			2003	\$ 8,159,910	\$ 308,673	28	\$ 296,724	\$ (11,949)	\$ 4,946,900	1
2									0		2
3									0		3
4									0		4
5									0		5
	Improvement Type										
6	Leasehold Improvements				236,973	467	15	15,798	15,332	231,684	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)				\$ 8,396,883	\$ 309,140		\$ 312,522	\$ 3,383	\$ 5,178,584	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	\$ 902,009	\$ 32,139	\$ 180,402	148,263	5	\$ 861,242	18
19		0	0	0	\$		-	19
20	TOTAL (lines 18 and 19)	\$ 902,009	\$ 32,139	\$ 180,402	148,263		\$ 861,242	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: CAMBRIDGE HOUSE OF OFALLON

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	
	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	GERSHMAN MORTGAGE		X	FIRST MORTGAGE	8/30/19	\$ 8,223,200	\$ 8,079,181	9/1/54	0.0380	\$ 309,039	1
2											2
3											3
	Working Capital										
4	BANK OF SPRINGFIELD		X	PPP LOAN	4/10/20	277,400	0	4/10/22	0.0100	1,778	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 8,500,600	\$ 8,079,181			\$ 310,817	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 8,500,600	\$ 8,079,181			\$ 310,817	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: CAMBRIDGE HOUSE OF OFALLON

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,170,805	\$	1
2	Cash-Patient Deposits	0		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (47,204))	193,760		3
4	Supply Inventory (priced at)	0		4
5	Short-Term Investments	0		5
6	Prepaid Insurance	102,760		6
7	Other Prepaid Expenses	19,502		7
8	Accounts Receivable (owners or related parties)	0		8
9	Other(specify): See Page 7 Attachment	2,370		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,489,197	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0		11
12	Long-Term Investments	0		12
13	Land	1,028,000		13
14	Buildings, at Historical Cost	8,159,910		14
15	Leasehold Improvements, at Historical Cost	236,973		15
16	Equipment, at Historical Cost	902,009		16
17	Accumulated Depreciation (book methods)	(6,039,826)		17
18	Deferred Charges	6,008		18
19	Organization & Pre-Operating Costs	0		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0		20
21	Restricted Funds	1,201,832		21
22	Other Long-Term Assets (specify):	0		22
23	Other(specify): See Page 7 Attachment	71,954		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,566,859	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,056,055	\$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 84,416	\$	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	59,501		30
31	Accrued Taxes Payable	68,943		31
32	Accrued Interest Payable	25,584		32
33	Deferred Compensation	0		33
34	Federal and State Income Taxes	0		34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	1,543,023		35
36		0		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,781,467	\$ 0	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	0		38
39	Mortgage Payable	7,866,794		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)	\$ 7,866,794	\$ 0	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 9,648,261	\$ 0	45
46	TOTAL EQUITY	\$ (1,592,205)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,056,055	\$ 0	47

*(See instructions.)

Facility Name: CAMBRIDGE HOUSE OF OFALLON

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	\$ 4,078,425	1
2	Discounts and Allowances	(32,706)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,045,719	3
	B. Other Operating Revenue		
4	Special Services	169,096	4
5	Other Health Care Services	0	5
6	Special Grants	641,726	6
7	Gift and Coffee Shop	0	7
8	Barber and Beauty Care	2,817	8
9	Non-Resident Meals	537	9
10	Laundry	0	10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 814,176	11
	C. Non-Operating Revenue		
12	Contributions	0	12
13	Interest and Other Investment Income	19,274	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 19,274	14
	D. Other Revenue (specify):		
15	See Page 8 Attachment	12,872	15
16		0	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 12,872	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,892,041	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,034,494	19
20	Health Care/ Personal Care	613,121	20
21	General Administration	1,224,164	21
	B. Capital Expense		
22	Ownership	1,985,779	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)	\$ 4,857,558	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 34,483	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 34,483	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,984,483	32
33	Private Pay - Net Inpatient Revenue	2,061,236	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 4,045,719	37

Operating Expenses PG 3 Other					
A. General Services			D. Ownership		
Labor Other (specify):			Other (specify):		Amt
9900-9001-0-0	Extraordinary COVID Labor	59,705	9100-9101-0-0	Interest & Dividend Income	
9900-9001-0-2	Extraordinary COVID - Labor	-	9100-9102-0-0	Assessment Income	-
	PG3-4.1	59,705	9100-9103-0-0	Assessment Expense	-
A. General Services			9200-9201-1-0	Amortization - Loan Fees	6,309
Other (specify):			9200-9202-0-0	Financing Fees	-
5200-5000-0-0	Operating Allocation	119,410	9200-9203-1-0	Mortgage Interest Premium	-
5200-5124-0-0	Exterminating	1,289	9200-9204-0-0	Mortgage Service Fee	-
5200-5127-0-0	Rubbish Removal	7,867	9200-9205-0-0	Mortgage Insurance Prem	70,272
5200-5130-0-0	Vehicle Expense	15,403	9200-9206-0-0	Participation Fee	-
5200-5131-0-0	Transportation Service	-	9200-9207-0-0	Letter of Credit Fee	-
5300-5140-0-0	Security & Monitoring	2,910	9200-9208-0-0	Bond & Draw Fee	-
9900-9002-0-0	Extraordinary COVID - Supplies & Equipment	42,449	9200-9209-0-0	Remarketing and Trustee Fee	-
9900-9003-0-0	Extraordinary COVID - Other	5,139	9200-9210-0-0	Interest Expense-Note	-
	PG3-4.3	75,057	9200-9211-0-0	Interest Expense-LP	-
C. General Administration			9200-9212-0-0	Debt Write-Off	-
Other (specify):			9300-9301-0-0	Partnership Management Fee	25,000
5160-5060-0-0	Consulting	1,826	9300-9302-0-0	Asset Management Fee	-
5160-5063-0-0	Legal	1,094	9300-9303-0-0	Incentive Management	1,158,620
5160-5064-0-0	Accounting	155	9300-9303-1-0	Incentive Asset Mgmt Fee	-
5160-5066-0-0	Audit	16,310	9300-9304-0-0	Tax Credit Fees & Incentive Fee	3,775
5160-5067-0-0	Contract Labor-Serv Prov	-	9300-9305-0-0	Organizational Expense	-
5160-5068-0-0	Contract Labor	40,734	9300-9306-0-0	Developer Fees	-
5180-5079-0-0	Bad Debt - Resident	185,674	9300-9307-0-0	Closing Costs	-
5180-5079-1-0	Bad Debt - Resident - Recovery	-	9700-9702-0-0	Amortization Expense	-
5180-5080-0-0	Bad Debt - Resident Prior Period	-	9900-9901-0-0	Prior Period Adjustments	-
5180-5081-0-0	Bad Debt - Medicaid Pending Denial	-	9900-9902-0-0	Dissolution of Business	-
5180-5081-1-0	Bad Debt - Medicaid Pending - Recovery	-	9900-9903-0-0	Loss (Gain) on Sale of Assets	-
5180-5082-0-0	Bad Debt - Medicaid Denial Prior Period	-	9900-9904-0-0	Business Interruption	-
5180-5083-0-0	Bad Debt - Medicaid MCO	4,815	9900-9905-0-0	Settlement	-
5190-5000-0-0	Other Admin Allocation	-	9900-9906-0-0	Property Damage Loss	-
	PG3-14.3	73,573	9900-9907-0-0	Abandonment Loss	-
			9900-9908-0-0	Grant Income	-
			9900-9909-0-0	Misc: Title, Recording, Transfer	-
			PG3-22.3	1,263,975	

Operating Expenses - Reclassifications and Adjustments PG 3			
A. General Services			
Heat and Other Utilities			
3300-3303-0-0	Cable		22,604
	PG3-3.5		22,604
C. General Administration			
Administrative and Clerical			
3300-3301-0-0	Beauty Salon & Manicure		2,817
3300-3304-0-0	Internet Access		-
3300-3321-0-0	Telephone- Connection		11,816
3300-3323-0-0	Telephone- Usage		259
5190-5090-0-0	Contributions		5,000
	PG3-10.5		19,892
C. General Administration			
Other (specify):			
5180-5079-0-0	Bad Debt - Resident		8,639
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		4,815
	PG3-14.5		13,454
D. Ownership			
Interest			
3300-3380-0-0	Interest Income		16,448
3300-3385-0-0	Interest Income - Reserves		2,826
	PG3-18.5		19,274
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	2,120
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	250
1102-9978-0-0	A/R-TIF/Abatement	-
1105-0009-0-0	Transfer Account	-
1105-0012-0-0	Undeposited Funds	-
PG7-9.1		2,370
Other Long Term Assets Detail		
1201-0020-0-0	CIP	71,954
1201-0021-0-0	CIP- Land Option Addition	-
1201-0022-0-0	CIP- Other Addition	-
PG7-23.1		71,953.60

Current Liabilities Detail		Amt
2111-0040-0-0	Construction Account Payable	-
2112-0100-0-0	Accrued Asset Management Fee	-
2112-0101-0-0	Accrued Partnership Mgmt Fee	25,000
2112-0102-0-0	Accrued Incentive Mgmt Fee	1,423,681
2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
2112-0105-0-0	Accrued Liabilities	31,932
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	510
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	14,095
2112-0159-1-0	Medicaid Prepayments	47,806
2112-0159-2-0	Prepaid Medicaid Clearing	-
2112-0159-3-0	Prepaid Rent	-
PG7-35.1		1,543,023

Income Statement PG 8 Other

Income Statement			
Other Revenue		Amt	
3300-3388-0-0	Contract Service-Serv Prov	-	
3300-3390-0-0	Other	11,312	Call Pendants; Late Fees
3300-3391-0-0	Property Tax Adjustments	-	
3300-3392-0-0	Property Lease Income	1,560	
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

12,872