

		FOR BHF USE			

LL2

Supportive Living Facility

2021

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2021)

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: 1000085</p> <p>Facility Name: HERITAGE WOODS OF ROCKFORD</p> <p>Address: 202 N SHOWPLACE DR ROCKFORD 61107</p> <p>County: WINNEBAGO</p> <p>Telephone Number: (815) 332-5777 Fax # 815 332-3407</p> <p>Federal Employer ID Number:</p> <p>Date Current Owners were Certified: 9/3/2008</p> <p>Type of Ownership:</p> <table><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:</p> <p>Name: Danel Erickson Telephone Number: (779) 771-6947</p> <p>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 01/01/2021 to 12/31/2021 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><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) Greg Echols</td><td></td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Title) CFO, Gardant Management Solutions</td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td><td></td></tr><tr><td>(Firm Name & Address) _____</td><td></td></tr><tr><td>(Telephone) () _____ Fax # () _____</td><td></td></tr></table> <p>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) Greg Echols		Paid Preparer	(Title) CFO, Gardant Management Solutions		(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																							
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	(Telephone) () _____ Fax # () _____																																								

Facility Name HERITAGE WOODS OF ROCKFORDReport Period Beginning: 01/01/2021 Ending: 12/31/2021**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	<u>99</u>	Single Unit Apartment	<u>99</u>	<u>36,135</u>	1
2	<u>0</u>	Double Unit Apartment	<u>0</u>	<u>0</u>	2
3		Other			3
4	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	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	<u>31,039</u>	<u>4,850</u>		<u>35,889</u>	5
6	Double Unit				<u>0</u>	6
7	Other				<u>0</u>	7
8	TOTALS	<u>31,039</u>	<u>4,850</u>	<u>0</u>	<u>35,889</u>	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.32%

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

586 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 3 (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

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☒ YES ☐ NOTax Year: 2021 Fiscal Year: 2021

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? Yes If yes, did the facility make all of the required payments of interest and principle? Yes

If no, explain. _____

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? No If yes, did the facility make all of the required payments of interest and principle? _____

If no, explain. _____

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? No If yes, did the facility make all of the required payments of interest and principle? _____

If no, explain. _____

Facility Name: HERITAGE WOODS OF ROCKFORD

Report Period Beginning:

01/01/2021

Ending:

12/31/2021

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	236,422	242,556	3,154	482,132	0	482,132	1
2	Housekeeping, Laundry and Maintenance	142,645	35,816	62,170	240,631	0	240,631	2
3	Heat and Other Utilities			144,794	144,794	(22,752)	122,042	3
4	Other (specify):	24,284	0	70,934	95,218	0	95,218	4
5	TOTAL General Services	403,351	278,372	281,052	962,776	(22,752)	940,024	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	863,164	19,309	0	882,473	0	882,473	6
7	Activities and Social Services	47,914	7,828	0	55,742	0	55,742	7
8	Other (specify):	0	0	0	0	0	0	8
9	TOTAL Health Care and Programs	911,078	27,137	0	938,215	0	938,215	9
	C. General Administration							
10	Administrative and Clerical	278,622	42,030	325,981	646,632	(19,453)	627,179	10
11	Marketing Materials, Promotions and Advertising	66,274	9,582	27,093	102,950	0	102,950	11
12	Employee Benefits and Payroll Taxes	0	0	270,074	270,074	0	270,074	12
13	Insurance-Property, Liability and Malpractice	0	0	78,105	78,105	0	78,105	13
14	Other (specify):	0	0	659,757	659,757	(81,317)	578,439	14
15	TOTAL General Administration	344,896	51,612	1,361,009	1,757,517	(100,770)	1,656,746	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,659,325	357,122	1,642,061	3,658,508	(123,523)	3,534,985	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			447,861	447,861	0	447,861	17
18	Interest			286,414	286,414	(6,436)	279,978	18
19	Real Estate Taxes			101,970	101,970	0	101,970	19
20	Rent -- Facility and Grounds			0	0	0	0	20
21	Rent -- Equipment			17,703	17,703	0	17,703	21
22	Other (specify):	0	0	941,365	941,365	0	941,365	22
23	TOTAL Ownership	0	0	1,795,313	1,795,313	(6,436)	1,788,877	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,659,325	357,122	3,437,374	5,453,821	(129,959)	5,323,862	24

Facility Name: HERITAGE WOODS OF ROCKFORD

Report Period Beginning: 01/01/2021 Ending: 12/31/2021

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	31.06	2
3	Certified Nurse Assistants	11	14.78	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	7	12.96	7
8	Dishwashers	0	0.00	8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	13.46	10
11	Laundry	0	0.00	11
12	Managers	4	28.01	12
13	Other Administrative	4	27.14	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)	31	\$	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
none			

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	\$ 234,744	1
2			2
Total		\$ 234,744	3

VIII. OWNERSHIP COSTS

A. Purchase price of land 416,192 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	99			2007	\$ 9,961,183	\$ 359,660	27.5	\$ 362,225	\$ 2,565	\$ 5,087,968	1
2									0		2
3									0		3
4									0		4
5									0		5
	Improvement Type										
6	Leasehold Improvements				698,214	41,771	15.0	46,548	4,777	641,688	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)				\$ 10,659,397	\$ 401,431		\$ 408,772	\$ 7,341	\$ 5,729,656	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	\$ 989,478	\$ 46,430	\$ 197,896	151,466	5	\$ 866,260	18
19			0	0	\$		-	19
20	TOTAL (lines 18 and 19)	\$ 989,478	\$ 46,430	\$ 197,896	151,466		\$ 866,260	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

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	IHDA		X	FIRST MORTGAGE	8/24/18	\$ 6,687,041	\$ 6,404,707	9/1/53	0.0438	\$ 266,251	1
2	IHDA		X	Second Mortgage	8/24/18	1,914,283	1,763,374	9/1/53	0.0100	17,849	2
3									0.0438		3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 8,601,324	\$ 8,168,081			\$ 284,100	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 8,601,324	\$ 8,168,081			\$ 284,100	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 OF ROCKFORD

Report Period Beginning: 01/01/2021

Ending: 12/31/2021

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2021

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,544,047	\$	1
2	Cash-Patient Deposits	680		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (147,778))	0 915,445		3
4	Supply Inventory (priced at)	0		4
5	Short-Term Investments	0		5
6	Prepaid Insurance	29,149		6
7	Other Prepaid Expenses	11,358		7
8	Accounts Receivable (owners or related parties)	0		8
9	Other(specify): See Page 7 Attachment	663		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,501,342	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0		11
12	Long-Term Investments	0		12
13	Land	416,192		13
14	Buildings, at Historical Cost	9,961,183		14
15	Leasehold Improvements, at Historical Cost	698,214		15
16	Equipment, at Historical Cost	989,478		16
17	Accumulated Depreciation (book methods)	(6,595,916)		17
18	Deferred Charges	337		18
19	Organization & Pre-Operating Costs	22,733		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0 (22,733)		20
21	Restricted Funds	1,286,161		21
22	Other Long-Term Assets (specify):	0		22
23	Other(specify): See Page 7 Attachment	3,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,758,647	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,259,989	\$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 159,342	\$	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	109,306		31
32	Accrued Interest Payable	23,517		32
33	Deferred Compensation	0		33
34	Federal and State Income Taxes	0		34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	1,993,580		35
36		0		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 2,285,745	\$ 0	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	0		38
39	Mortgage Payable	7,824,736		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)	\$ 7,824,736	\$ 0	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,110,481	\$ 0	45
46	TOTAL EQUITY	\$ (850,492)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,259,989	\$ 0	47

*(See instructions.)

Facility Name: HERITAGE WOODS OF ROCKFORD

Report Period Beginning: 01/01/2021

Ending:

12/31/2021

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	\$ 5,294,731	1
2	Discounts and Allowances	(3,155)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 5,291,576	3
	B. Other Operating Revenue		
4	Special Services	289,113	4
5	Other Health Care Services	0	5
6	Special Grants	301,538	6
7	Gift and Coffee Shop	0	7
8	Barber and Beauty Care	0	8
9	Non-Resident Meals	0	9
10	Laundry	0	10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 590,651	11
	C. Non-Operating Revenue		
12	Contributions	0	12
13	Interest and Other Investment Income	6,436	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 6,436	14
	D. Other Revenue (specify):		
15	See Page 8 Attachment	3,006	15
16		0	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 3,006	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 5,891,669	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	962,776	19
20	Health Care/ Personal Care	938,215	20
21	General Administration	1,757,517	21
	B. Capital Expense		
22	Ownership	1,795,313	22
	C. Other Expenses		
23	Special Cost Centers	0	23
24	Non-Operating Expenses	0	24
25	Other (specify):	0	25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 5,453,821	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 437,848	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 437,848	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 3,039,204	32
33	Private Pay - Net Inpatient Revenue	2,252,372	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 5,291,576	37

Operating Expenses PG 3 Other			
A. General Services		D. Ownership	
Labor Other (specify):		Other (specify):	
Extraordinary COVID Labor	\$ 24,284	Interest & Dividend Income	\$ -
PG3-4.1	\$ 24,284	Assessment Income	\$ -
		Assessment Expense	\$ -
A. General Services		Amortization - Loan Fees	\$ 11,484
Other (specify):		Financing Fees	\$ -
Exterminating	\$ 2,286	Mortgage Interest Premium	\$ -
Rubbish Removal	\$ 10,365	Mortgage Service Fee	\$ -
Vehicle Expense	\$ 14,754	Mortgage Insurance Prem	\$ 15,883
Transportation Service	\$ -	Letter of Credit Fee	\$ -
Security & Monitoring	\$ 11,455	Bond & Draw Fee	\$ -
Extraordinary COVID - Supplies & Equipment	\$ 26,207	Remarketing and Trustee Fee	\$ -
Extraordinary COVID - Other	\$ 5,866	Interest Expense-Note	\$ -
PG3-4.3	\$ 70,934	Interest Expense-LP	\$ -
		Debt Write-Off	\$ -
C. General Administration		Partnership/Priority Mgmt Fee	\$ -
Other (specify):		Asset Mgmt/Investor Service Fee	\$ 40,317
Consulting	\$ 344,419	Incentive Management	\$ 685,376
Legal	\$ 24,475	Incentive Asset Mgmt Fee	\$ 143,952
Audit & Accounting	\$ 19,326	Tax Credit Fees	\$ 5,353
Contract Labor-Serv Prov	\$ 160,899	Organizational Expense	\$ -
Contract Labor	\$ 29,320	Developer Fees	\$ -
Bad Debt - Resident	\$ 50,328	Amortization Expense	\$ -
Bad Debt - Resident - Recovery	\$ -	Prior Period Adjustments	\$ -
Bad Debt - Medicaid Pending Denial	\$ 18,903	Loss (Gain) on Sale of Assets	\$ (1,000)
Bad Debt - Medicaid Pending - Recovery	\$ -	Settlement	\$ -
Bad Debt - Medicaid	\$ -	Property Damage Loss	\$ -
Bad Debt - Medicaid Recovery	\$ -	Abandonment Loss	\$ -
Bad Debt - Medicaid MCO	\$ 12,086	Grant Income	\$ -
PG3-14.3	\$ 659,757	PG3-22.3	\$ 901,365

Operating Expenses - Reclassifications and Adjustments PG3			
A. General Services			
Heat and Other Utilities			
Cable	\$ 22,752		
PG3-3.5	\$ 22,752		
C. General Administration			
Administrative and Clerical			
Beauty Salon & Manicure	\$ -		
Internet Access	\$ 4,891		
Telephone- Connection	\$ 11,809		
Telephone- Usage	\$ 253		
Contributions	\$ 2,500		
PG3-10.5	\$ 19,453		
C. General Administration			
Other (specify):			
Bad Debt - Resident	\$ 50,328		
Bad Debt - Resident - Recovery	\$ -		
Bad Debt - Medicaid Pending Denial	\$ 18,903		
Bad Debt - Medicaid Pending - Recovery	\$ -		
Bad Debt - Medicaid	\$ -		
Bad Debt - Medicaid Recovery	\$ -		
Bad Debt - Medicaid MCO	\$ 12,086		
PG3-14.5	\$ 81,317		
D. Ownership			
Interest:			
Interest Income	\$ 5,725		
Interest Income - Reserves	\$ 711		
PG3-18.5	\$ 6,436		
D. Ownership			
Other (specify):			
Goodwill Amortization	\$ -		
Remarketing and Trustee Fee	\$ -		
PG3-22.5	\$ -		

Balance Sheet PG 7 Other					
A. Other Current Asset Details			C. Current Liabilities Detail		
A/R-Employee Advance	\$	-	Construction Account Payable	\$	-
A/R-Gardant Mgmt Solutions	\$	-	Accrued Asset Mgmt/Investor Service Fee	\$	-
A/R-Insurance Reimbursement	\$	-	Accrued Partnership/Priority Mgmt Fee	\$	-
A/R-CIP	\$	-	Accrued Incentive Mgmt Fee	\$	1,608,510
A/R-Other	\$	663	Accrued Incentive Asset Mgmt Fee	\$	-
A/R-TIF/Abatement	\$	-	Accrued Liabilities	\$	71,548
PG7-9.1	\$	663	Accrued Insurance	\$	-
B. Other Long Term Assets Detail			Accrued Developer Fee	\$	-
CIP	\$	-	Accrued MIP	\$	-
CIP- Land Option Addition	\$	3,000	Accrued Vacation	\$	-
CIP- Other Addition	\$	-	Payroll Union Dues	\$	-
PG7-23.1	\$	3,000	Payroll Benefits	\$	-
			Security Deposits Held	\$	-
			Unclaimed Property	\$	1,595
			Reservation Deposit	\$	-
			Unearned Revenue - Resident	\$	54,180
			Unearned Revenue - Medicaid	\$	257,747
			Prepaid Medicaid Clearing	\$	-
			Prepaid Rent	\$	-
			PG7-35.1	\$	1,993,580

Income Statement PG 8 Other			
D. Other Revenue			Notes
Contract Service-Serv Prov	\$	-	
Other	\$	1,305	Late fees
Property Tax Adjustments	\$	-	
Property Lease Income	\$	1,701	
Insurance Adjustments	\$	-	
Developer Fee Income	\$	-	
Home Office Rent Income	\$	-	
Food & Meal Prep	\$	-	
PG8-15.1	\$	3,006	