

		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: 1000150</p> <p>Facility Name: LACEY CREEK</p> <p>Address: 4800 LACEY ROAD DOWNERS GROVE 60515</p> <p>County: DUPAGE</p> <p>Telephone Number: (630) 964-7720 Fax # 630 964-4229</p> <p>Federal Employer ID Number:</p> <p>Date Current Owners were Certified: 8/23/2017</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 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 checked="" type="checkbox"/> "Sub-S" Corp.</td><td></td></tr><tr><td></td><td><input checked="" type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other</td><td></td></tr></table> <p>In the event there are further questions about this report, please contact:</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 type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from 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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	(Firm Name & Address) _____																																								
	(Telephone) () _____ Fax # () _____																																								

Facility Name LACEY CREEKReport 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>120</u>	Single Unit Apartment	<u>120</u>	<u>43,800</u>	1
2	<u>0</u>	Double Unit Apartment	<u>0</u>	<u>0</u>	2
3		Other			3
4	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</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>32,804</u>	<u>4,899</u>		<u>37,703</u>	5
6	Double Unit				<u>0</u>	6
7	Other				<u>0</u>	7
8	TOTALS	<u>32,804</u>	<u>4,899</u>	<u>0</u>	<u>37,703</u>	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 86.08%

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

971 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 191 (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 ☐ NO

Tax 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? 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: LACEY CREEK

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	244,511	224,583	1,477	470,570	0	470,570	1
2	Housekeeping, Laundry and Maintenance	121,065	36,518	145,439	303,021	0	303,021	2
3	Heat and Other Utilities			187,839	187,839	(27,857)	159,982	3
4	Other (specify):	11,292	0	91,377	102,670	0	102,670	4
5	TOTAL General Services	376,868	261,101	426,132	1,064,100	(27,857)	1,036,243	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	690,494	23,467	0	713,961	0	713,961	6
7	Activities and Social Services	56,010	10,036	0	66,046	0	66,046	7
8	Other (specify):	0	0	0	0	0	0	8
9	TOTAL Health Care and Programs	746,505	33,502	0	780,007	0	780,007	9
	C. General Administration							
10	Administrative and Clerical	263,078	59,466	346,954	669,498	(15,503)	653,995	10
11	Marketing Materials, Promotions and Advertising	59,731	10,295	45,902	115,927	0	115,927	11
12	Employee Benefits and Payroll Taxes	0	0	265,519	265,519	0	265,519	12
13	Insurance-Property, Liability and Malpractice	0	0	171,708	171,708	0	171,708	13
14	Other (specify):	0	0	268,367	268,367	(130,001)	138,366	14
15	TOTAL General Administration	322,808	69,761	1,098,450	1,491,019	(145,503)	1,345,516	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,446,181	364,364	1,524,582	3,335,126	(173,360)	3,161,766	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			718,862	718,862	0	718,862	17
18	Interest			1,143,999	1,143,999	(2,983)	1,141,016	18
19	Real Estate Taxes			96,142	96,142	0	96,142	19
20	Rent -- Facility and Grounds			0	0	0	0	20
21	Rent -- Equipment			23,814	23,814	0	23,814	21
22	Other (specify):	0	0	(1,317,369)	(1,317,369)	3,000	(1,314,369)	22
23	TOTAL Ownership	0	0	665,447	665,447	17	665,464	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,446,181	364,364	2,190,029	4,000,573	(173,343)	3,827,230	24

Facility Name: LACEY CREEK

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	27.84	2
3	Certified Nurse Assistants	13	16.21	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	4	14.22	7
8	Dishwashers	0	0.00	8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	2	13.06	10
11	Laundry	0	0.00	11
12	Managers	6	25.75	12
13	Other Administrative	5	25.61	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)	32	\$	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	\$ 292,254	1
2			2
Total		\$ 292,254	3

Facility Name: LACEY CREEK Report Period Beginning: 01/01/2021 Ending: 12/31/2021

VIII. OWNERSHIP COSTS

A. Purchase price of land 2,117,546 Year land was acquired 2015

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar. *Total units on this schedule must agree with page 2.

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	120			2016	\$ 20,063,798	\$ 501,599	40.0	\$ 501,595	\$ (4)	\$ 2,590,364	1
2									0		2
3									0		3
4									0		4
5									0		5
	Improvement Type										
6	Leasehold Improvements				1,780,428	89,017	20.0	89,021	4	455,902	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)				\$ 21,844,225	\$ 590,616		\$ 590,616	\$ 1	\$ 3,046,266	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	\$ 1,222,466	\$ 122,246	\$ 122,247	1	10	\$ 604,297	18
19	Vehicles	\$ 59,990	\$ 6,000	\$ 5,999	(1)	10	\$ 31,000	19
20	TOTAL (lines 18 and 19)	\$ 1,282,456	\$ 128,246	\$ 128,246	(0)		\$ 635,297	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	HEARTLAND BANK and TR			FIRST MORTGAGE	12/1/17	\$ 20,114,920	\$ 19,177,360	12/1/32	0.0562	\$ 1,098,398	1
2	HEARTLAND BANK and TRUST			Second Mortgage	12/1/17	835,080	795,840	12/1/32	0.0562	45,585	2
3											3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 20,950,000	\$ 19,973,200			\$ 1,143,983	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 20,950,000	\$ 19,973,200			\$ 1,143,983	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: LACEY CREEK

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	\$ 343,360	\$	1
2	Cash-Patient Deposits	363		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (461,162))	0 1,332,560		3
4	Supply Inventory (priced at)	0		4
5	Short-Term Investments	0		5
6	Prepaid Insurance	74,960		6
7	Other Prepaid Expenses	15,028		7
8	Accounts Receivable (owners or related parties)	41,095		8
9	Other(specify):	0		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,807,366	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0		11
12	Long-Term Investments	0		12
13	Land	2,117,546		13
14	Buildings, at Historical Cost	20,063,798		14
15	Leasehold Improvements, at Historical Cost	1,780,428		15
16	Equipment, at Historical Cost	1,282,456		16
17	Accumulated Depreciation (book methods)	(3,681,562)		17
18	Deferred Charges	35		18
19	Organization & Pre-Operating Costs	813,913		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0 (36,955)		20
21	Restricted Funds	3,496,154		21
22	Other Long-Term Assets (specify):	0		22
23	Other(specify):	0		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 25,835,811	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 27,643,177	\$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 84,953	\$	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	100,070		31
32	Accrued Interest Payable	96,573		32
33	Deferred Compensation	0		33
34	Federal and State Income Taxes	0		34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	1,122,670		35
36		0		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,404,266	\$ 0	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	0		38
39	Mortgage Payable	19,960,650		39
40	Bonds Payable	0		40
41	Deferred Compensation	0		41
	Other Long-Term Liabilities(specify):			
42	FMV of Derivative	3,054,833		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 23,015,483	\$ 0	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 24,419,749	\$ 0	45
46	TOTAL EQUITY	\$ 3,223,429	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 27,643,177	\$ 0	47

*(See instructions.)

Facility Name: LACEY CREEK

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	\$ 5,741,821	1
2	Discounts and Allowances	(2,554)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 5,739,267	3
	B. Other Operating Revenue		
4	Special Services	218,841	4
5	Other Health Care Services	0	5
6	Special Grants	8,136	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)	\$ 226,977	11
	C. Non-Operating Revenue		
12	Contributions	0	12
13	Interest and Other Investment Income	2,983	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,983	14
	D. Other Revenue (specify):		
15	See Page 8 Attachment	10,570	15
16		0	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 10,570	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 5,979,797	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,064,100	19
20	Health Care/ Personal Care	780,007	20
21	General Administration	1,491,019	21
	B. Capital Expense		
22	Ownership	665,447	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)	\$ 4,000,573	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 1,979,224	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 1,979,224	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 3,510,102	32
33	Private Pay - Net Inpatient Revenue	2,229,165	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 5,739,267	37

Operating Expenses PG 3 Other			
A. General Services		D. Ownership	
Labor Other (specify):		Other (specify):	
Extraordinary COVID Labor	\$ 11,292	Interest & Dividend Income	\$ -
PG3-4.1	\$ 11,292	Assessment Income	\$ -
		Assessment Expense	\$ -
A. General Services		Amortization - Loan Fees	\$ 21,284
Other (specify):		Financing Fees	\$ -
Exterminating	\$ 7,289	Mortgage Interest Premium	\$ -
Rubbish Removal	\$ 17,999	Mortgage Service Fee	\$ -
Vehicle Expense	\$ 2,039	Mortgage Insurance Prem	\$ -
Transportation Service	\$ -	Letter of Credit Fee	\$ -
Security & Monitoring	\$ 19,471	Bond & Draw Fee	\$ -
Extraordinary COVID - Supplies & Equipment	\$ 35,947	Remarketing and Trustee Fee	\$ 3,000
Extraordinary COVID - Other	\$ 8,633	Interest Expense-Note	\$ -
PG3-4.3	\$ 91,377	Interest Expense-LP	\$ -
		Debt Write-Off	\$ -
C. General Administration		Partnership/Priority Mgmt Fee	\$ -
Other (specify):		Asset Mgmt/Investor Service Fee	\$ 12,500
Consulting	\$ 1,536	Incentive Management	\$ -
Legal	\$ 83,089	Incentive Asset Mgmt Fee	\$ -
Audit & Accounting	\$ 14,110	Tax Credit Fees	\$ 3,375
Contract Labor-Serv Prov	\$ (4,959)	Organizational Expense	\$ -
Contract Labor	\$ 44,590	Developer Fees	\$ -
Bad Debt - Resident	\$ 154,458	Amortization Expense	\$ 7,391
Bad Debt - Resident - Recovery	\$ -	Prior Period Adjustments	\$ -
Bad Debt - Medicaid Pending Denial	\$ (31,667)	Loss (Gain) on Sale of Assets	\$ (1,365,919)
Bad Debt - Medicaid Pending - Recovery	\$ -	Settlement	\$ -
Bad Debt - Medicaid	\$ -	Property Damage Loss	\$ 1,000
Bad Debt - Medicaid Recovery	\$ -	Abandonment Loss	\$ -
Bad Debt - Medicaid MCO	\$ 7,209	Grant Income	\$ -
PG3-14.3	\$ 268,367	PG3-22.3	\$ (1,317,369)

Operating Expenses - Reclassifications and Adjustments PG3			
A. General Services			
Heat and Other Utilities			
Cable	\$ 27,857		
PG3-3.5	\$ 27,857		
C. General Administration			
Administrative and Clerical			
Beauty Salon & Manicure	\$ -		
Internet Access	\$ 3,803		
Telephone- Connection	\$ 5,465		
Telephone- Usage	\$ 3,735		
Contributions	\$ 2,500		
PG3-10.5	\$ 15,503		
C. General Administration			
Other (specify):			
Bad Debt - Resident	\$ 154,458		
Bad Debt - Resident - Recovery	\$ -		
Bad Debt - Medicaid Pending Denial	\$ (31,667)		
Bad Debt - Medicaid Pending - Recovery	\$ -		
Bad Debt - Medicaid	\$ -		
Bad Debt - Medicaid Recovery	\$ -		
Bad Debt - Medicaid MCO	\$ 7,209		
PG3-14.5	\$ 130,001		
D. Ownership			
Interest:			
Interest Income	\$ 2,073		
Interest Income - Reserves	\$ 910		
PG3-18.5	\$ 2,983		
D. Ownership			
Other (specify):			
Goodwill Amortization	\$ -		
Remarketing and Trustee Fee	\$ 3,000		
PG3-22.5	\$ 3,000		

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	\$	12,500
A/R-Insurance Reimbursement	\$	-	Accrued Partnership/Priority Mgmt Fee	\$	-
A/R-CIP	\$	-	Accrued Incentive Mgmt Fee	\$	-
A/R-Other	\$	-	Accrued Incentive Asset Mgmt Fee	\$	-
A/R-TIF/Abatement	\$	-	Accrued Liabilities	\$	87,438
PG7-9.1	\$	-	Accrued Insurance	\$	-
			Accrued Developer Fee	\$	634,310
B. Other Long Term Assets Detail			Accrued MIP	\$	-
CIP	\$	-	Accrued Vacation	\$	-
CIP- Land Option Addition	\$	-	Payroll Union Dues	\$	-
CIP- Other Addition	\$	-	Payroll Benefits	\$	-
PG7-23.1	\$	-	Security Deposits Held	\$	-
			Unclaimed Property	\$	1,940
			Reservation Deposit	\$	-
			Unearned Revenue - Resident	\$	56,586
			Unearned Revenue - Medicaid	\$	329,896
			Prepaid Medicaid Clearing	\$	-
			Prepaid Rent	\$	-
			PG7-35.1	\$	1,122,670

Income Statement PG 8 Other			
D. Other Revenue			Notes
Contract Service-Serv Prov	\$	-	
Other	\$	1,570	Call pendants; returned check fees
Property Tax Adjustments	\$	-	
Property Lease Income	\$	9,000	
Insurance Adjustments	\$	-	
Developer Fee Income	\$	-	
Home Office Rent Income	\$	-	
Food & Meal Prep	\$	-	
PG8-15.1	\$	10,570	