

		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: 1000145</p> <p>Facility Name: ST ANTHONY OF LANSING</p> <p>Address: 3025 SPRING LAKE DR LANSING 60438</p> <p>County: COOK</p> <p>Telephone Number: (708) 474-6100 Fax # 708 474-6102</p> <p>Federal Employer ID Number:</p> <p>Date Current Owners were Certified: 6/17/2009</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 # () _____																																									

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

A. Certified units; enter number of units and unit days

Date of change in certified units

/ /

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)**

B. Census-For the entire report period.

H. ACCOUNTING BASIS

MODIFIED

ACCRUAL	X
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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.

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) **83.36%**

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

983 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. **79 (Do not include bed-hold days in Section B.)**

STATE OF ILLINOIS

Page 3

Facility Name: ST ANTHONY OF LANSING

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	278,409	230,495	2,288	511,192	0	511,192	1
2	Housekeeping, Laundry and Maintenance	175,853	49,220	46,080	271,153	0	271,153	2
3	Heat and Other Utilities			160,303	160,303	(29,907)	130,397	3
4	Other (specify):	14,835	0	83,565	98,400	0	98,400	4
5	TOTAL General Services	469,097	279,714	292,236	1,041,048	(29,907)	1,011,141	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	749,118	25,731	0	774,850	0	774,850	6
7	Activities and Social Services	45,161	16,167	0	61,329	0	61,329	7
8	Other (specify):	0	0	0	0	0	0	8
9	TOTAL Health Care and Programs	794,280	41,899	0	836,178	0	836,178	9
	C. General Administration							
10	Administrative and Clerical	279,786	64,042	385,031	728,859	(24,013)	704,847	10
11	Marketing Materials, Promotions and Advertising	49,284	14,966	68,977	133,227	0	133,227	11
12	Employee Benefits and Payroll Taxes	0	0	325,685	325,685	0	325,685	12
13	Insurance-Property, Liability and Malpractice	0	0	162,530	162,530	0	162,530	13
14	Other (specify):	0	0	(157,790)	(157,790)	(108,304)	(266,094)	14
15	TOTAL General Administration	329,070	79,008	784,433	1,192,510	(132,317)	1,060,193	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,592,447	400,621	1,076,669	3,069,737	(162,224)	2,907,513	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			603,360	603,360	0	603,360	17
18	Interest			1,194,402	1,194,402	(3,906)	1,190,496	18
19	Real Estate Taxes			327,748	327,748	0	327,748	19
20	Rent -- Facility and Grounds			0	0	0	0	20
21	Rent -- Equipment			15,166	15,166	0	15,166	21
22	Other (specify):	0	0	914,288	914,288	3,957	918,245	22
23	TOTAL Ownership	0	0	3,054,965	3,054,965	51	3,055,016	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,592,447	400,621	4,131,634	6,124,701	(162,173)	5,962,529	24

Facility Name: ST ANTHONY OF LANSING

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	2	27.37	2
3	Certified Nurse Assistants	17	15.35	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	8	14.00	7
8	Dishwashers	0	0.00	8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	4	13.63	10
11	Laundry	0	0.00	11
12	Managers	5	26.41	12
13	Other Administrative	6	22.77	13
14	Clerical	Inc line 13	Inc line 13	14
15	Marketing	Inc line 12	Inc line 12	15
16	Other	0	0.00	16
17	Total (lines 1 thru 16)	42	\$	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
DEER PATH SLF, LLC	

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).

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	\$ 305,619	1
2			2
Total		\$ 305,619	3

Facility Name: ST ANTHONY OF LANSING

Report Period Beginning:

01/01/2021

Ending:

12/31/2021

VIII. OWNERSHIP COSTSA. 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	\$ 17,653,175	\$ 440,781	40.0	\$ 441,329	\$ 549	\$ 3,687,257	1
2									0		2
3									0		3
4									0		4
5									0		5
	Improvement Type										
6	Leasehold Improvements				357,005	16,350	20.0	17,850	1,500	136,805	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)				\$ 18,010,180	\$ 457,131		\$ 459,180	\$ 2,049	\$ 3,824,061	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	\$ 1,476,104	\$ 146,229	\$ 147,610	1,381	10	\$ 1,199,851	18
19					\$		-	19
20	TOTAL (lines 18 and 19)	\$ 1,476,104	\$ 146,229	\$ 147,610	1,381		\$ 1,199,851	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	AMALGAMATED BANK		X	FIRST MORTGAGE	7/13/12	\$ 18,630,000	\$ 0	12/1/32	0.0650	\$ 1,166,175	1
2	COUNTY OF COOK		X	Second Mortgage	7/12/12	3,000,000	3,000,000	7/12/54	none		2
3	MERCHANTS CAPITAL		X	FIRST MORTGAGE	12/14/21	19,462,900	19,462,900	7/12/54	0.0256	24,913	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 41,092,900	\$ 22,462,900			\$ 1,191,088	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 41,092,900	\$ 22,462,900			\$ 1,191,088	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: 01/01/2021

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	\$ 822,553	\$	1
2	Cash-Patient Deposits	1,536		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (322,388))	0 1,481,021		3
4	Supply Inventory (priced at)	0		4
5	Short-Term Investments	0		5
6	Prepaid Insurance	248,203		6
7	Other Prepaid Expenses	4,254		7
8	Accounts Receivable (owners or related parties)	93,177		8
9	Other(specify):	0		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,650,745	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0		11
12	Long-Term Investments	0		12
13	Land	2,558,268		13
14	Buildings, at Historical Cost	17,653,175		14
15	Leasehold Improvements, at Historical Cost	357,005		15
16	Equipment, at Historical Cost	1,476,104		16
17	Accumulated Depreciation (book methods)	(5,023,912)		17
18	Deferred Charges	590		18
19	Organization & Pre-Operating Costs	1,000,212		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0 (362,094)		20
21	Restricted Funds	840,115		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)	\$ 18,499,463	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 21,150,208	\$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 162,826	\$	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	305,049		31
32	Accrued Interest Payable	0		32
33	Deferred Compensation	0		33
34	Federal and State Income Taxes	0		34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	803,178		35
36		0		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,271,053	\$ 0	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	0		38
39	Mortgage Payable	21,884,680		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)	\$ 21,884,680	\$ 0	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 23,155,732	\$ 0	45
46	TOTAL EQUITY	\$ (2,005,524)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 21,150,208	\$ 0	47

*(See instructions.)

Facility Name: ST ANTHONY OF LANSING

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	\$ 5,636,670	1
2	Discounts and Allowances	(25,875)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 5,610,795	3
	B. Other Operating Revenue		
4	Special Services	279,678	4
5	Other Health Care Services	0	5
6	Special Grants	8,872	6
7	Gift and Coffee Shop	0	7
8	Barber and Beauty Care	500	8
9	Non-Resident Meals	0	9
10	Laundry	0	10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 289,050	11
	C. Non-Operating Revenue		
12	Contributions	0	12
13	Interest and Other Investment Income	3,906	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 3,906	14
	D. Other Revenue (specify):		
15	See Page 8 Attachment	4,161	15
16		0	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 4,161	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 5,907,912	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,041,048	19
20	Health Care/ Personal Care	836,178	20
21	General Administration	1,192,510	21
	B. Capital Expense		
22	Ownership	3,054,965	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)	\$ 6,124,701	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (216,789)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (216,789)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 3,955,623	32
33	Private Pay - Net Inpatient Revenue	1,655,171	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 5,610,794	37

Operating Expenses PG 3 Other			
A. General Services		D. Ownership	
Labor Other (specify):		Other (specify):	
Extraordinary COVID Labor	\$ 14,835	Interest & Dividend Income	\$ -
PG3-4.1	\$ 14,835	Assessment Income	\$ -
		Assessment Expense	\$ -
A. General Services		Amortization - Loan Fees	\$ 662,128
Other (specify):		Financing Fees	\$ 180,300
Exterminating	\$ 3,616	Mortgage Interest Premium	\$ -
Rubbish Removal	\$ 34,978	Mortgage Service Fee	\$ -
Vehicle Expense	\$ 3,148	Mortgage Insurance Prem	\$ 11,758
Transportation Service	\$ 1,004	Letter of Credit Fee	\$ -
Security & Monitoring	\$ 8,836	Bond & Draw Fee	\$ -
Extraordinary COVID - Supplies & Equipment	\$ 27,130	Remarketing and Trustee Fee	\$ 3,957
Extraordinary COVID - Other	\$ 4,853	Interest Expense-Note	\$ -
PG3-4.3	\$ 83,565	Interest Expense-LP	\$ -
		Debt Write-Off	\$ -
C. General Administration		Partnership/Priority Mgmt Fee	\$ -
Other (specify):		Asset Mgmt/Investor Service Fee	\$ 10,000
Consulting	\$ 1,536	Incentive Management	\$ -
Legal	\$ 22,080	Incentive Asset Mgmt Fee	\$ -
Audit & Accounting	\$ 15,020	Tax Credit Fees	\$ 3,125
Contract Labor-Serv Prov	\$ (346,678)	Organizational Expense	\$ -
Contract Labor	\$ 41,948	Developer Fees	\$ -
Bad Debt - Resident	\$ 85,548	Amortization Expense	\$ 43,021
Bad Debt - Resident - Recovery	\$ -	Prior Period Adjustments	\$ -
Bad Debt - Medicaid Pending Denial	\$ (3,271)	Loss (Gain) on Sale of Assets	\$ -
Bad Debt - Medicaid Pending - Recovery	\$ -	Settlement	\$ -
Bad Debt - Medicaid	\$ -	Property Damage Loss	\$ -
Bad Debt - Medicaid Recovery	\$ -	Abandonment Loss	\$ -
Bad Debt - Medicaid MCO	\$ 26,028	Grant Income	\$ -
PG3-14.3	\$ (157,790)	PG3-22.3	\$ 914,288

Operating Expenses - Reclassifications and Adjustments PG3			
A. General Services			
Heat and Other Utilities			
Cable	\$ 29,907		
PG3-3.5	\$ 29,907		
C. General Administration			
Administrative and Clerical			
Beauty Salon & Manicure	\$ 500		
Internet Access	\$ 17		
Telephone- Connection	\$ 18,013		
Telephone- Usage	\$ 2,982		
Contributions	\$ 2,500		
PG3-10.5	\$ 24,013		
C. General Administration			
Other (specify):			
Bad Debt - Resident	\$ 85,548		
Bad Debt - Resident - Recovery	\$ -		
Bad Debt - Medicaid Pending Denial	\$ (3,271)		
Bad Debt - Medicaid Pending - Recovery	\$ -		
Bad Debt - Medicaid	\$ -		
Bad Debt - Medicaid Recovery	\$ -		
Bad Debt - Medicaid MCO	\$ 26,028		
PG3-14.5	\$ 108,304		
D. Ownership			
Interest:			
Interest Income	\$ 3,170		
Interest Income - Reserves	\$ 736		
PG3-18.5	\$ 3,906		
D. Ownership			
Other (specify):			
Goodwill Amortization	\$ -		
Remarketing and Trustee Fee	\$ 3,957		
PG3-22.5	\$ 3,957		

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	\$	476,811
A/R-Other	\$	-	Accrued Incentive Asset Mgmt Fee	\$	-
A/R-TIF/Abatement	\$	-	Accrued Liabilities	\$	66,810
PG7-9.1	\$	-	Accrued Insurance	\$	-
B. Other Long Term Assets Detail			Accrued Developer Fee	\$	-
CIP	\$	-	Accrued MIP	\$	-
CIP- Land Option Addition	\$	-	Accrued Vacation	\$	-
CIP- Other Addition	\$	-	Payroll Union Dues	\$	-
PG7-23.1	\$	-	Payroll Benefits	\$	-
			Security Deposits Held	\$	-
			Unclaimed Property	\$	4,571
			Reservation Deposit	\$	-
			Unearned Revenue - Resident	\$	28,204
			Unearned Revenue - Medicaid	\$	226,782
			Prepaid Medicaid Clearing	\$	-
			Prepaid Rent	\$	-
			PG7-35.1	\$	803,178

Income Statement PG 8 Other		
D. Other Revenue		Notes
Contract Service-Serv Prov	\$ -	
Other	\$ 4,161	
Property Tax Adjustments	\$ -	
Property Lease Income	\$ -	
Insurance Adjustments	\$ -	
Developer Fee Income	\$ -	
Home Office Rent Income	\$ -	
Food & Meal Prep	\$ -	
PG8-15.1	\$ 4,161	