

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2014  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2014)**

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>1000041</u></p> <p><b>Facility Name:</b> <u>CHURCHVIEW SUPPORTIVE LV CTR</u></p> <p><b>Address:</b> <u>2626 WEST 63RD ST</u> <u>CHICAGO</u> <u>60629</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> ( <u>773</u> ) <u>471-4444</u> Fax # <u>773 471-3935</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>03/24/2005</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</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input checked="" type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>FAITH STEWART</u> <b>Telephone Number:</b> <u>815-935-1992 EXT. 257</u></p> <p><b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<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><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>01/01/2014</u> to <u>12/31/2014</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 border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>David J. Mitchell</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>CFO, BMA Management, LTD</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name &amp; Address) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) ( <u>   </u> ) _____ Fax # ( <u>   </u> ) _____</td> </tr> </table> <p align="right">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) <u>David J. Mitchell</u>		(Title) <u>CFO, BMA Management, LTD</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) ( <u>   </u> ) _____ Fax # ( <u>   </u> ) _____
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Facility Name CHURCHVIEW SUPPORTIVE LV CTR

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

**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	86	Single Unit Apartment	86	31,390	1
2		Double Unit Apartment			2
3		Other			3
4	86	TOTALS	86	31,390	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	26,759	1,144		27,903	5
6	Double Unit					6
7	Other					7
8	TOTALS	26,759	1,144		27,903	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.89%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 657 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 207 (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: 2014 Fiscal Year: 2014

\* 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: CHURCHVIEW SUPPORTIVE LV CTR

Report Period Beginning:

01/01/2014

Ending: 12/31/2014

## 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	208,491	147,675	2,182	358,348		358,348	1
2	Housekeeping, Laundry and Maintenance	87,989	37,371	114,345	239,705		239,705	2
3	Heat and Other Utilities			207,206	207,206	(9,249)	197,957	3
4	Other (specify):			63,774	63,774		63,774	4
5	<b>TOTAL General Services</b>	<b>296,480</b>	<b>185,046</b>	<b>387,507</b>	<b>869,033</b>	<b>(9,249)</b>	<b>859,784</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	367,133	1,452		368,585		368,585	6
7	Activities and Social Services	38,416	6,209		44,625		44,625	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>405,549</b>	<b>7,661</b>		<b>413,210</b>		<b>413,210</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	171,373	14,379	254,958	440,710	(18,032)	422,678	10
11	Marketing Materials, Promotions and Advertising	56,270	10,091	34,250	100,611		100,611	11
12	Employee Benefits and Payroll Taxes			266,638	266,638		266,638	12
13	Insurance-Property, Liability and Malpractice			47,227	47,227		47,227	13
14	Other (specify):			136,619	136,619		136,619	14
15	<b>TOTAL General Administration</b>	<b>227,643</b>	<b>24,470</b>	<b>739,692</b>	<b>991,805</b>	<b>(18,032)</b>	<b>973,773</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>929,672</b>	<b>217,177</b>	<b>1,127,199</b>	<b>2,274,048</b>	<b>(27,281)</b>	<b>2,246,767</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			462,738	462,738		462,738	17
18	Interest			7,425	7,425		7,425	18
19	Real Estate Taxes			75,512	75,512		75,512	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			158,177	158,177		158,177	22
23	<b>TOTAL Ownership</b>			<b>703,852</b>	<b>703,852</b>		<b>703,852</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>929,672</b>	<b>217,177</b>	<b>1,831,051</b>	<b>2,977,900</b>	<b>(27,281)</b>	<b>2,950,619</b>	<b>24</b>

Facility Name: CHURCHVIEW SUPPORTIVE LV CTR

Report Period Beginning 01/01/2014 Ending: 12/31/2014

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 1	1
2	Licensed Practical Nurses	1	25.02	2
3	Certified Nurse Assistants	11	10.43	3
4	Activity Director & Assistants	Inc line 12	Inc line 1	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	8	10.19	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 1	9
10	Housekeepers	3	9.82	10
11	Laundry			11
12	Managers	5	22.50	12
13	Other Administrative	4	20.27	13
14	Clerical	Inc line 13	Inc line 1	14
15	Marketing	Inc line 12	Inc line 1	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>32</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>6</b>

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1	BMA Management, LTD	\$	138,061	1	
2				2	
		<b>Total</b>	<b>\$</b>	<b>138,061</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

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: CHURCHVIEW SUPPORTIVE LV CTR

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land 1,302,647 Year land was acquired 1998-2000

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	86			2004	\$ 12,319,858	\$ 448,073	28	\$ 447,995	\$ (78)	\$ 4,637,925	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		LAND IMPROVEMENTS			292,999	8,516	15	19,533	11,017	199,942	6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 12,612,857	\$ 456,589		\$ 467,528	\$ 10,939	\$ 4,837,867	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	\$ 389,126	\$ 6,149	\$ 77825.2	71,676	5	\$ 299,278	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 389,126	\$ 6,149	\$ 77,825	71,676		\$ 299,278	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: CHURCHVIEW SUPPORTIVE LV CTR

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

**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>				\$			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				
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1	HARRIS TRUST & SAVING		X	FIRST MORTGAGE	03/01/03	\$ 7,555,000	\$ 6,190,000	09/01/33	VARIABLE	\$ 7,425.39	1
2	CITY OF CHICAGO DEPT C		X	SECOND MORTGAGE	03/01/35	\$ 4,000,000	\$ 4,000,000	03/01/35	NONE	\$	2
3					/ /	\$	\$	/ /		\$	3
	<b>Working Capital</b>										
4					/ /	\$	\$	/ /		\$	4
5					/ /	\$	\$	/ /		\$	5
6					/ /	\$	\$	/ /		\$	6
7	<b>TOTAL Facility Related</b>					\$ 11,555,000	\$ 10,190,000			\$ 7,425	7
	<b>B. Non-Facility Related</b>										
8					/ /	\$	\$	/ /		\$	8
9					/ /	\$	\$	/ /		\$	9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 11,555,000	\$ 10,190,000			\$ 7,425	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: CHURCHVIEW SUPPORTIVE LV CTR

Report Period Beginning: 01/01/2014

Ending:

12/31/2014

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 123,516	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,001,933 (106,224)		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,304		6
7	Other Prepaid Expenses	1,474		7
8	Accounts Receivable (owners or related parties)	7,984		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,043,987	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,302,647		13
14	Buildings, at Historical Cost	12,319,858		14
15	Leasehold Improvements, at Historical Cost	292,999		15
16	Equipment, at Historical Cost	389,126		16
17	Accumulated Depreciation (book methods)	(5,137,145)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	582,880		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(335,643)		20
21	Restricted Funds	1,340,791		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 10,755,513	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 11,799,499	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 73,363	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	73,235		31
32	Accrued Interest Payable	636		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	See Attachment	253,741		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 400,975	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	10,190,000		39
40	Bonds Payable			40
41	Deferred Compensation			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>	\$ 10,190,000	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 10,590,975	\$	45
46	<b>TOTAL EQUITY</b>	\$ 1,208,525	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 11,799,499	\$	47

\*(See instructions.)

Facility Name: CHURCHVIEW SUPPORTIVE LV CTR

Report Period Beginning: 01/01/2014

Ending:

12/31/2014

## XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 2,761,492	1
2	Discounts and Allowances	(60,231)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 2,701,261</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services	147,284	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	671	8
9	Non-Resident Meals	367	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 148,322</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	15,055	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 15,055</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16	Insurance Adjustments	7,697	16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 7,697</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 2,872,335</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	869,033	19
20	Health Care/ Personal Care	413,210	20
21	General Administration	991,805	21
<b>B. Capital Expense</b>			
22	Ownership	703,852	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 2,977,900</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (105,565)</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ (105,565)</b>	<b>31</b>

## Expenses PG 3 Other

General Services Detail		Amt
5200-5124-0-0	Exterminating	9,406
5200-5127-0-0	Rubbish Removal	18,123
5300-5140-0-0	Security & Monitoring	31,168
5200-5130-0-0	Vehicle Expense	-
5200-5131-0-0	Transportation Service	5,077
5200-5132-0-0	Water Softener	-
5200-5133-0-0	Window Washing	-
5200-5137-0-0	Miscellaneous Oper Expense	-

63,774

General Administration Detail		Amt
5160-5060-0-0	Consulting	-
5160-5063-0-0	Legal	20,873
5160-5064-0-0	Accounting	105
5160-5066-0-0	Audit	10,834
5160-5067-0-0	Contract Labor-Serv Prov	-
5160-5068-0-0	Contract Labor	1,200
5180-9999-0-0	Total Bad Debt	103,607

136,619



	Ownership Other detail	Amt
9100-9101-0-0	Interest & Dividend Income	-
9100-9102-0-0	Assessment Income	-
9100-9103-0-0	Assessment Expense	-
9200-9202-0-0	Financing Fees	-
9200-9204-0-0	Mortgage Service Fee	-
9200-9205-0-0	Mortgage Insurance Prem	-
9200-9206-0-0	Participation Fee	-
9200-9207-0-0	Letter of Credit Fee	79,832
9200-9208-0-0	Bond & Draw Fee	2,400
9200-9209-0-0	Remarketing and Trustee Fee	13,886
9200-9212-0-0	Debt Write-Off	-
9300-9301-0-0	Partnership Management Fee	43,000
9300-9302-0-0	Asset Management Fee	4,300
9300-9303-0-0	Incentive Management	-
9300-9303-1-0	Incentive Asset Mgmt Fee	-
9300-9304-0-0	Tax Credit Fees & Incentive Fee	2,150
9300-9305-0-0	Organizational Expense	-
9300-9306-0-0	Developer Fees	-
9300-9307-0-0	Closing Costs	-
9700-9702-0-0	Amortization Expense	12,609
9900-9901-0-0	Prior Period Adjustments	-
9900-9902-0-0	Dissolution of Business	-
9900-9903-0-0	Loss (Gain) on Sale of Assets	-
9900-9904-0-0	Business Interruption	-
9900-9905-0-0	Settlement	-
9900-9906-0-0	Property Damage Loss	-
9900-9907-0-0	Abandonment Loss	-
9900-9908-0-0	Grant Income	-
9900-9909-0-0	Misc: Title, Recording, Transfer	-
		158,177



Balance Sheet

Other Current Assets Detail		Amt	Current Liabilities Detail		Amt
1102-9970-0-0	A/R-Medicaid Food Stamps	-	2112-0100-0-0	Accrued Asset Management Fee	4,300
1102-9971-0-0	A/R-Employee Advance	-	2112-0101-0-0	Accrued Partnership Mgmt Fee	-
1102-9973-0-0	A/R-Insurance Reimbursement	-	2112-0102-0-0	Accrued Incentive Mgmt Fee	150,045
1102-9974-0-0	A/R-Subscription Receivable	-	2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
1102-9975-0-0	A/R-CIP	-	2112-0105-0-0	Accrued Liabilities	48,254
1102-9976-0-0	A/R-Other	-	2112-0110-0-0	Accrued Insurance	-
1102-9978-0-0	A/R-TIF/Abatement	-	2112-0115-0-0	Accrued Developer Fee	-
			2112-0130-0-0	Accrued MIP	-
			2112-0146-0-0	Payroll Benefits	-
			2112-0154-0-0	Unclaimed Property	22,185
			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	28,958
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
			2112-0170-0-0	Line of Credit	-
			2112-0175-0-0	Loan - Vehicle	-
		-			253,741

