

		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>I. Facility ID Number: <u>100X026</u></p> <p>Facility Name: <u>EAGLE RIDGE SLF II</u></p> <p>Address: <u>875 MCKINLEY AVENUE</u> <u>DECATUR</u> <u>62526</u> <small>Number City Zip Code</small></p> <p>County: <u>MACON</u></p> <p>Telephone Number: (<u>217</u>) <u>872-1282</u> Fax # <u>217 872-1227</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>08/02/2007</u></p> <p>Type of Ownership:</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;">IRS Exemption Code _____</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>In the event there are further questions about this report, please contact:</p> <p>Name: <u>SHANE ALLEE</u> Telephone Number: <u>815-935-1992 EXT. 246</u></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 <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; vertical-align: top;">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; vertical-align: top;">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 & 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>) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name: EAGLE RIDGE SLF II

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			
A. General Services								
1	Dietary and Food Purchase	75,868	74,041	677	150,586		150,586	1
2	Housekeeping, Laundry and Maintenance	41,364	8,405	25,926	75,695		75,695	2
3	Heat and Other Utilities			49,277	49,277	(10,259)	39,018	3
4	Other (specify):			8,795	8,795		8,795	4
5	TOTAL General Services	117,232	82,446	84,675	284,353	(10,259)	274,094	5
B. Health Care and Programs								
6	Health Care/ Personal Care	163,369	1,271		164,640		164,640	6
7	Activities and Social Services	2,843	2,812		5,655		5,655	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	166,212	4,083		170,295		170,295	9
C. General Administration								
10	Administrative and Clerical	23,562	4,446	135,620	163,628	(11,452)	152,176	10
11	Marketing Materials, Promotions and Advertising	3,053	2,152	18,307	23,512		23,512	11
12	Employee Benefits and Payroll Taxes			70,285	70,285		70,285	12
13	Insurance-Property, Liability and Malpractice			17,362	17,362		17,362	13
14	Other (specify):			90,715	90,715		90,715	14
15	TOTAL General Administration	26,615	6,598	332,289	365,502	(11,452)	354,050	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	310,059	93,127	416,964	820,150	(21,711)	798,439	16
Capital Expenses								
D. Ownership								
17	Depreciation			156,770	156,770		156,770	17
18	Interest			183,182	183,182		183,182	18
19	Real Estate Taxes			45,358	45,358		45,358	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			118,626	118,626		118,626	22
23	TOTAL Ownership			503,936	503,936		503,936	23
24	GRAND TOTAL (Sum of lines 16 and 23)	310,059	93,127	920,900	1,324,086	(21,711)	1,302,375	24

Facility Name: EAGLE RIDGE SLF II

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	20.02	2
3	Certified Nurse Assistants	6	10.23	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	3	9.45	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 1	9
10	Housekeepers	1	9.32	10
11	Laundry			11
12	Managers	1	21.07	12
13	Other Administrative	1	21.39	13
14	Clerical	Inc line 13	Inc line 1	14
15	Marketing	Inc line 12	Inc line 1	15
16	Other			16
17	Total (lines 1 thru 16)	13	\$	17

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	\$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	BMA Management, LTD	\$ 66,176	1
2			2
		Total	\$ 66,176 3

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
EAGLE RIDGE OF DECATUR		DECATUR	

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: EAGLE RIDGE SLF II

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land 50,000 Year land was acquired 2006

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	37			2007	\$ 3,919,621	\$ 142,532	28	\$ 142,532	\$ (0)	\$ 1,057,007	1
2											2
3											3
4											4
5											5
Improvement Type											
6	LAND IMPROVEMENTS				476,265	1,395	15	31,751	30,356	254,801	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)				\$ 4,395,886	\$ 143,927		\$ 174,283	\$ 30,356	\$ 1,311,808	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	\$ 619,362	\$ 9,537	\$ 123,872	114,335	5	\$ 604,195	18
19	Vehicles	17,221	3,306	3,444	138	5	12,260	19
20	TOTAL (lines 18 and 19)	\$ 636,583	\$ 12,843	\$ 127,316	114,473		\$ 616,455	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: **EAGLE RIDGE SLF II**

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	TOTAL				\$			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	10/01/06	\$ 3,370,000	\$ 3,172,342	02/01/48	.0544	\$ 173,566.63	1
2	IHDA		X	SECOND MORTGAGE	10/01/06	\$ 1,100,000	\$ 948,618	02/01/48	.0100	\$ 9,615	2
3					/ /	\$	\$	/ /		\$	3
	Working Capital										
4					/ /	\$	\$	/ /		\$	4
5					/ /	\$	\$	/ /		\$	5
6					/ /	\$	\$	/ /		\$	6
7	TOTAL Facility Related					\$ 4,470,000	\$ 4,120,960			\$ 183,182	7
	B. Non-Facility Related										
8					/ /	\$	\$	/ /		\$	8
9					/ /	\$	\$	/ /		\$	9
10	TOTALS (lines 7, 8 and 9)					\$ 4,470,000	\$ 4,120,960			\$ 183,182	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: EAGLE RIDGE SLF II

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 142,421	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	271,809 (4,303)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,660		6
7	Other Prepaid Expenses	1,327		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 416,915	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	3,919,621		14
15	Leasehold Improvements, at Historical Cost	476,265		15
16	Equipment, at Historical Cost	636,583		16
17	Accumulated Depreciation (book methods)	(1,928,263)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	192,143		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(39,578)		20
21	Restricted Funds	964,602		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,271,373	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,688,288	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 67,607	\$	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	48,871		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Attachment	117,368		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 233,846	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,120,960		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 4,120,960	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,354,806	\$	45
46	TOTAL EQUITY	\$ 333,482	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,688,288	\$	47

*(See instructions.)

Facility Name: EAGLE RIDGE SLF II

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	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,282,850	1
2	Discounts and Allowances	(9,915)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,272,935	3
B. Other Operating Revenue			
4	Special Services	54,939	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	4,076	8
9	Non-Resident Meals	2,364	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 61,379	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	4,915	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 4,915	14
D. Other Revenue (specify):			
15			15
16	Insurance Adjustments	4,977	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 4,977	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,344,206	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	284,353	19
20	Health Care/ Personal Care	170,295	20
21	General Administration	365,502	21
B. Capital Expense			
22	Ownership	503,936	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)	\$ 1,324,086	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 20,120	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 20,120	31

Expenses PG 3 Other

	General Services Detail	Amt
5200-5124-0-0	Exterminating	1,733
5200-5127-0-0	Rubbish Removal	2,595
5300-5140-0-0	Security & Monitoring	2,645
5200-5130-0-0	Vehicle Expense	1,791
5200-5131-0-0	Transportation Service	31
5200-5132-0-0	Water Softener	-
5200-5133-0-0	Window Washing	-
5200-5137-0-0	Miscellaneous Oper Expense	-

	General Administration Detail	Amt
5160-5060-0-0	Consulting	2,038
5160-5063-0-0	Legal	1,027
5160-5064-0-0	Accounting	72
5160-5066-0-0	Audit	12,435
5160-5067-0-0	Contract Labor-Serv Prov	68,405
5160-5068-0-0	Contract Labor	1,782
5180-9999-0-0	Total Bad Debt	4,956

8,795

90,715

	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	14,441
9200-9206-0-0	Participation Fee	-
9200-9207-0-0	Letter of Credit Fee	-
9200-9208-0-0	Bond & Draw Fee	-
9200-9209-0-0	Remarketing and Trustee Fee	-
9200-9212-0-0	Debt Write-Off	-
9300-9301-0-0	Partnership Management Fee	35,000
9300-9302-0-0	Asset Management Fee	20,000
9300-9303-0-0	Incentive Management	43,000
9300-9303-1-0	Incentive Asset Mgmt Fee	-
9300-9304-0-0	Tax Credit Fees & Incentive Fee	725
9300-9305-0-0	Organizational Expense	-
9300-9306-0-0	Developer Fees	-
9300-9307-0-0	Closing Costs	-
9700-9702-0-0	Amortization Expense	5,460
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	-
		118,626

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	20,000
1102-9971-0-0	A/R-Employee Advance	-	2112-0101-0-0	Accrued Partnership Mgmt Fee	35,000
1102-9973-0-0	A/R-Insurance Reimbursement	-	2112-0102-0-0	Accrued Incentive Mgmt Fee	43,000
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	12,600
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	-
			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	6,768
			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	-
		-			117,368

