

		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>1000115</u></p> <p><b>Facility Name:</b> <u>HERITAGE WOODS OF BOLINGBRK</u></p> <p><b>Address:</b> <u>550 KILDEER</u> <u>BOLINGBROOK</u> <u>60440</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>WILL</u></p> <p><b>Telephone Number:</b> ( <u>630</u> ) <u>783-9640</u> Fax # <u>630 783-9648</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>02/27/2009</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>SHANE ALLEE</u> <b>Telephone Number:</b> <u>815-935-1992 Ext 246</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) ( ) _____ Fax # ( ) _____</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) ( ) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name HERITAGE WOODS OF BOLINGBROOK

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	105	Single Unit Apartment	105	38,325	1
2		Double Unit Apartment			2
3		Other			3
4	105	TOTALS	105	38,325	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	31,575	6,527		38,102	5
6	Double Unit					6
7	Other					7
8	TOTALS	31,575	6,527		38,102	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.)       99.42%      

**D. Indicate the number of paid bed-hold days the SLF had during this year**       1,082       Also, indicate the number of unpaid bed-hold days the SLF had during this year.                      **(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**

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: HERITAGE WOODS OF BOLINGBROOK

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	246,728	202,031	1,837	450,596		450,596	1
2	Housekeeping, Laundry and Maintenance	107,382	29,723	59,594	196,699		196,699	2
3	Heat and Other Utilities			180,747	180,747	(28,003)	152,744	3
4	Other (specify):			28,436	28,436		28,436	4
5	<b>TOTAL General Services</b>	<b>354,110</b>	<b>231,754</b>	<b>270,614</b>	<b>856,478</b>	<b>(28,003)</b>	<b>828,475</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	463,546	2,891		466,437		466,437	6
7	Activities and Social Services	31,884	9,832		41,716		41,716	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>495,430</b>	<b>12,723</b>		<b>508,153</b>		<b>508,153</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	176,191	12,354	303,181	491,726	(27,695)	464,031	10
11	Marketing Materials, Promotions and Advertising	59,981	9,722	50,378	120,081		120,081	11
12	Employee Benefits and Payroll Taxes			259,263	259,263		259,263	12
13	Insurance-Property, Liability and Malpractice			46,639	46,639		46,639	13
14	Other (specify):			68,723	68,723		68,723	14
15	<b>TOTAL General Administration</b>	<b>236,172</b>	<b>22,076</b>	<b>728,184</b>	<b>986,432</b>	<b>(27,695)</b>	<b>958,737</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,085,712</b>	<b>266,553</b>	<b>998,798</b>	<b>2,351,063</b>	<b>(55,698)</b>	<b>2,295,365</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			519,771	519,771		519,771	17
18	Interest			807,743	807,743		807,743	18
19	Real Estate Taxes			105,743	105,743		105,743	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			515,566	515,566		515,566	22
23	<b>TOTAL Ownership</b>			<b>1,948,823</b>	<b>1,948,823</b>		<b>1,948,823</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,085,712</b>	<b>266,553</b>	<b>2,947,621</b>	<b>4,299,886</b>	<b>(55,698)</b>	<b>4,244,188</b>	<b>24</b>

Facility Name: HERITAGE WOODS OF BOLINGBROOK

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	21.02	2
3	Certified Nurse Assistants	15	11.11	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	10	9.33	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 1	9
10	Housekeepers	3	9.56	10
11	Laundry			11
12	Managers	5	23.94	12
13	Other Administrative	4	22.37	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>38</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	\$ 199,778	1
2			2
<b>Total</b>		<b>\$ 199,778</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: HERITAGE WOODS OF BOLINGBROOK

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land 815,542 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	105			2009	\$ 12,529,068	\$ 455,602	28	\$ 455,602	\$	\$ 2,691,502	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	LAND IMPROVEMENTS				242,571	16,171	15	16,171	(0)	95,681	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)				\$ 12,771,639	\$ 471,773		\$ 471,774	\$ (0)	\$ 2,787,183	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	\$ 712,825	\$ 47,998	\$ 142,565	94,567	5	\$ 665,857	18
19	Vehicles				-		-	19
20	TOTAL (lines 18 and 19)	\$ 712,825	\$ 47,998	\$ 142,565	94,567		\$ 665,857	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: HERITAGE WOODS OF BOLINGBROOK

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	AMALGAMATED BANK		X	FIRST MORTGAGE / BOND	12/01/07	\$ 11,900,000	\$ 11,420,000	12/01/42	.0700	\$ 807,742.67
2					/ /	\$	\$	/ /		\$
3					/ /	\$	\$	/ /		\$
	<b>Working Capital</b>									
4						\$	\$			\$
5					/ /	\$	\$	/ /		\$
6					/ /	\$	\$	/ /		\$
7	<b>TOTAL Facility Related</b>					\$ 11,900,000	\$ 11,420,000			\$ 807,743
	<b>B. Non-Facility Related</b>									
8					/ /	\$	\$	/ /		\$
9					/ /	\$	\$	/ /		\$
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 11,900,000	\$ 11,420,000			\$ 807,743

\* 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 BOLINGBROOK

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	\$ 179,916	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	429,044 (21,545)		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,405		6
7	Other Prepaid Expenses	2,127		7
8	Accounts Receivable (owners or related parties)	8,453		8
9	Other(specify):	3,140		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 615,541	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	815,542		13
14	Buildings, at Historical Cost	12,529,068		14
15	Leasehold Improvements, at Historical Cost	242,571		15
16	Equipment, at Historical Cost	712,825		16
17	Accumulated Depreciation (book methods)	(3,453,041)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	544,440		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(101,919)		20
21	Restricted Funds	2,147,522		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>	\$ 13,437,009	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 14,052,550	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 62,873	\$	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	102,292		31
32	Accrued Interest Payable	66,617		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	See Attachment	531,550		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 763,332	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,420,000		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>	\$ 11,420,000	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 12,183,332	\$	45
46	<b>TOTAL EQUITY</b>	\$ 1,869,218	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 14,052,550	\$	47

\*(See instructions.)

Facility Name: HERITAGE WOODS OF BOLINGBROOK

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	\$ 3,797,846	1
2	Discounts and Allowances	143	2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 3,797,989	3
<b>B. Other Operating Revenue</b>			
4	Special Services	169,327	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	8,863	8
9	Non-Resident Meals	3,541	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 181,731	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	12,547	13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$ 12,547	14
<b>D. Other Revenue (specify):</b>			
15			15
16	Insurance Adjustments	6,632	16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	\$ 6,632	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 3,998,899	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	856,478	19
20	Health Care/ Personal Care	508,153	20
21	General Administration	986,432	21
<b>B. Capital Expense</b>			
22	Ownership	1,948,823	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</b> (sum of lines 19 thru 27)	\$ 4,299,886	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ (300,987)	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ (300,987)	31

## Expenses PG 3 Other

General Services Detail		Amt
5200-5124-0-0	Exterminating	3,138
5200-5127-0-0	Rubbish Removal	5,774
5300-5140-0-0	Security & Monitoring	16,874
5200-5130-0-0	Vehicle Expense	2,050
5200-5131-0-0	Transportation Service	-
5200-5132-0-0	Water Softener	-
5200-5133-0-0	Window Washing	-
5200-5137-0-0	Miscellaneous Oper Expense	600

28,436

General Administration Detail		Amt
5160-5060-0-0	Consulting	25,000
5160-5063-0-0	Legal	3,115
5160-5064-0-0	Accounting	105
5160-5066-0-0	Audit	11,585
5160-5067-0-0	Contract Labor-Serv Prov	-
5160-5068-0-0	Contract Labor	19,922
5180-9999-0-0	Total Bad Debt	8,996

68,723



	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	1,000
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	-
9200-9208-0-0	Bond & Draw Fee	-
9200-9209-0-0	Remarketing and Trustee Fee	3,200
9200-9212-0-0	Debt Write-Off	-
9300-9301-0-0	Partnership Management Fee	-
9300-9302-0-0	Asset Management Fee	17,389
9300-9303-0-0	Incentive Management	438,417
9300-9303-1-0	Incentive Asset Mgmt Fee	25,792
9300-9304-0-0	Tax Credit Fees & Incentive Fee	2,075
9300-9305-0-0	Organizational Expense	-
9300-9306-0-0	Developer Fees	-
9300-9307-0-0	Closing Costs	-
9700-9702-0-0	Amortization Expense	17,193
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	10,000
9900-9906-0-0	Property Damage Loss	500
9900-9907-0-0	Abandonment Loss	-
9900-9908-0-0	Grant Income	-
9900-9909-0-0	Misc: Title, Recording, Transfer	-
		515,566



Balance Sheet

Other Current Assets Detail		Amt	Current Liabilities Detail		Amt
1102-9970-0-0	A/R-Medicaid Food Stamps	2,840	2112-0100-0-0	Accrued Asset Management Fee	17,389
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	438,417
1102-9974-0-0	A/R-Subscription Receivable	-	2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	25,792
1102-9975-0-0	A/R-CIP	-	2112-0105-0-0	Accrued Liabilities	27,742
1102-9976-0-0	A/R-Other	300	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	9,363
			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	12,847
			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	-
		3,140			531,550

