

		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>1000096</u></p> <p>Facility Name: <u>HERITAGE WOODS OF MOLINE</u></p> <p>Address: <u>5500 46TH AVENUE DR</u> <u>MOLINE</u> <u>61265</u> <small>Number City Zip Code</small></p> <p>County: <u>ROCK ISLAND</u></p> <p>Telephone Number: (<u>309</u>) <u>736-5655</u> Fax # <u>309 736-5651</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>11/17/2008</u></p> <p>Type of Ownership:</p> <table border="0"> <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 checked="" 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 type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input 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: <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"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>David J. Mitchell</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO, BMA Management, LTD</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <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 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																																								
<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 _____																																									
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 # () _____																																									

Facility Name HERITAGE WOODS OF MOLINE

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	99	Single Unit Apartment	99	36,135	1
2		Double Unit Apartment			2
3		Other			3
4	99	TOTALS	99	36,135	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	24,468	10,357		34,825	5
6	Double Unit					6
7	Other					7
8	TOTALS	24,468	10,357		34,825	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.37%

D. Indicate the number of paid bed-hold days the SLF had during this year 402 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 MOLINE

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	224,849	187,108	2,066	414,023		414,023	1
2	Housekeeping, Laundry and Maintenance	105,305	22,508	46,352	174,165		174,165	2
3	Heat and Other Utilities			121,218	121,218	(24,898)	96,320	3
4	Other (specify):			38,031	38,031		38,031	4
5	TOTAL General Services	330,154	209,616	207,667	747,437	(24,898)	722,539	5
B. Health Care and Programs								
6	Health Care/ Personal Care	387,252	3,571		390,823		390,823	6
7	Activities and Social Services	27,772	4,540		32,312		32,312	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	415,024	8,111		423,135		423,135	9
C. General Administration								
10	Administrative and Clerical	164,061	10,683	295,878	470,622	(38,305)	432,317	10
11	Marketing Materials, Promotions and Advertising	45,630	12,152	54,604	112,386		112,386	11
12	Employee Benefits and Payroll Taxes			255,538	255,538		255,538	12
13	Insurance-Property, Liability and Malpractice			41,932	41,932		41,932	13
14	Other (specify):			150,271	150,271		150,271	14
15	TOTAL General Administration	209,691	22,835	798,223	1,030,749	(38,305)	992,444	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	954,869	240,562	1,005,890	2,201,321	(63,204)	2,138,117	16
Capital Expenses								
D. Ownership								
17	Depreciation			424,254	424,254		424,254	17
18	Interest			619,950	619,950		619,950	18
19	Real Estate Taxes			86,655	86,655		86,655	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			520,808	520,808		520,808	22
23	TOTAL Ownership			1,651,667	1,651,667		1,651,667	23
24	GRAND TOTAL (Sum of lines 16 and 23)	954,869	240,562	2,657,557	3,852,988	(63,204)	3,789,784	24

Facility Name: HERITAGE WOODS OF MOLINE

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	19.91	2
3	Certified Nurse Assistants	14	9.50	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	9.27	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 1	9
10	Housekeepers	4	9.56	10
11	Laundry			11
12	Managers	5	19.55	12
13	Other Administrative	4	20.39	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)	38	\$	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	\$ 171,346	1	
2			2	
		Total	\$ 171,346	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

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 MOLINE

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land 158,031 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	99			2008	\$ 11,235,240	\$ 408,554	28	\$ 408,554	\$ 0	\$ 2,766,414	1
2											2
3											3
4											4
5											5
Improvement Type											
6	LAND IMPROVEMENTS				265,361	15,700	15	17,691	1,991	131,567	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)				\$ 11,500,601	\$ 424,254		\$ 426,245	\$ 1,991	\$ 2,897,981	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	\$ 623,790	\$	124,758	124,758	5	\$ 623,790	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 623,790	\$	124,758	124,758		\$ 623,790	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 MOLINE

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	AMALGAMATED		X	FIRST MORTGAGE / BOND	12/14/06	\$ 10,870,000	\$ 10,195,000	12/01/41	.0600	\$ 619,950.00	1
2					/ /	\$	\$	/ /		\$	2
3					/ /	\$	\$	/ /		\$	3
	Working Capital										
4					/ /	\$	\$	/ /		\$	4
5					/ /	\$	\$	/ /		\$	5
6					/ /	\$	\$	/ /		\$	6
7	TOTAL Facility Related					\$ 10,870,000	\$ 10,195,000			\$ 619,950	7
	B. Non-Facility Related										
8					/ /	\$	\$	/ /		\$	8
9					/ /	\$	\$	/ /		\$	9
10	TOTALS (lines 7, 8 and 9)					\$ 10,870,000	\$ 10,195,000			\$ 619,950	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: HERITAGE WOODS OF MOLINE

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	\$ 188,285	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	723,090 (112,193)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,568		6
7	Other Prepaid Expenses	4,557		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	2,013		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 835,319	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	158,031		13
14	Buildings, at Historical Cost	11,235,240		14
15	Leasehold Improvements, at Historical Cost	265,361		15
16	Equipment, at Historical Cost	623,790		16
17	Accumulated Depreciation (book methods)	(3,521,771)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	544,051		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(131,096)		20
21	Restricted Funds	1,745,363		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,918,969	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,754,288	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 42,224	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	16,620		30
31	Accrued Taxes Payable	90,501		31
32	Accrued Interest Payable	50,975		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Attachment	545,088		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 745,408	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	10,195,000		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)	\$ 10,195,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,940,408	\$	45
46	TOTAL EQUITY	\$ 813,879	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 11,754,288	\$	47

*(See instructions.)

Facility Name: HERITAGE WOODS OF MOLINE

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	\$ 3,408,600	1
2	Discounts and Allowances	(30,397)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,378,203	3
B. Other Operating Revenue			
4	Special Services	127,050	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	17,828	8
9	Non-Resident Meals	8,916	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 153,794	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	8,425	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 8,425	14
D. Other Revenue (specify):			
15			15
16	Insurance Adjustments	6,280	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 6,280	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,546,702	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	747,437	19
20	Health Care/ Personal Care	423,135	20
21	General Administration	1,030,749	21
B. Capital Expense			
22	Ownership	1,651,667	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)	\$ 3,852,988	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (306,286)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (306,286)	31

Expenses PG 3 Other

General Services Detail		Amt
5200-5124-0-0	Exterminating	2,342
5200-5127-0-0	Rubbish Removal	14,405
5300-5140-0-0	Security & Monitoring	10,290
5200-5130-0-0	Vehicle Expense	10,994
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	-

38,031

General Administration Detail		Amt
5160-5060-0-0	Consulting	30,112
5160-5063-0-0	Legal	1,764
5160-5064-0-0	Accounting	75
5160-5066-0-0	Audit	12,800
5160-5067-0-0	Contract Labor-Serv Prov	-
5160-5068-0-0	Contract Labor	4,709
5180-9999-0-0	Total Bad Debt	100,811

150,271

	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	3,200
9200-9209-0-0	Remarketing and Trustee Fee	-
9200-9212-0-0	Debt Write-Off	-
9300-9301-0-0	Partnership Management Fee	50,000
9300-9302-0-0	Asset Management Fee	5,004
9300-9303-0-0	Incentive Management	439,997
9300-9303-1-0	Incentive Asset Mgmt Fee	-
9300-9304-0-0	Tax Credit Fees & Incentive Fee	1,975
9300-9305-0-0	Organizational Expense	-
9300-9306-0-0	Developer Fees	-
9300-9307-0-0	Closing Costs	-
9700-9702-0-0	Amortization Expense	19,632
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	-
		520,808

Balance Sheet

Other Current Assets Detail		Amt	Current Liabilities Detail		Amt
1102-9970-0-0	A/R-Medicaid Food Stamps	2,013	2112-0100-0-0	Accrued Asset Management Fee	-
1102-9971-0-0	A/R-Employee Advance	-	2112-0101-0-0	Accrued Partnership Mgmt Fee	50,000
1102-9973-0-0	A/R-Insurance Reimbursement	-	2112-0102-0-0	Accrued Incentive Mgmt Fee	439,997
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	18,705
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	56
			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	36,331
			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	-
		2,013			545,088

