

		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>100X043</u></p> <p><b>Facility Name:</b> <u>PRAIRIE LVG AT CHAUTAUQUA II</u></p> <p><b>Address:</b> <u>955 VILLA COURT</u> <u>CARBONDALE</u> <u>62901</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>JACKSON</u></p> <p><b>Telephone Number:</b> ( <u>618</u> ) <u>351-7955</u> Fax # <u>618 351-6955</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>07/20/2010</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <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><b>IRS Exemption Code</b> _____</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 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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>SHANE ALLEE</u> <b>Telephone Number:</b> <u>815-935-1992 EXT. 246</u>  <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 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 checked="" 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%"> <tr> <td rowspan="2" style="width:20%;"><b>Officer or Administrator of Provider</b></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:20%;"><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name &amp; 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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>David J. Mitchell</u>			(Title) <u>CFO, BMA Management, LTD</u>		<b>Paid Preparer</b>	(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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	(Telephone) ( ) _____ Fax # ( ) _____																																									

Facility Name PRAIRIE LIVING WEST, LLC

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	47	Single Unit Apartment	47	18,250	1
2	3	Double Unit Apartment	3		2
3		Other			3
4	50	TOTALS	50	18,250	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	6,012	9,015		15,027	5
6	Double Unit					6
7	Other					7
8	TOTALS	6,012	9,015		15,027	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 82.34%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 149 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: PRAIRIE LIVING WEST, LLC

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	72,897	90,508	715	164,120		164,120	1
2	Housekeeping, Laundry and Maintenance	38,730	14,232	34,352	87,314		87,314	2
3	Heat and Other Utilities			61,889	61,889	(7,299)	54,590	3
4	Other (specify):			8,612	8,612		8,612	4
5	<b>TOTAL General Services</b>	<b>111,627</b>	<b>104,740</b>	<b>105,568</b>	<b>321,935</b>	<b>(7,299)</b>	<b>314,636</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	137,392	1,516		138,908		138,908	6
7	Activities and Social Services	14,698	3,893		18,591		18,591	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>152,090</b>	<b>5,409</b>		<b>157,499</b>		<b>157,499</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	62,353	8,050	127,254	197,657	(13,741)	183,916	10
11	Marketing Materials, Promotions and Advertising	5,267	3,688	21,054	30,009		30,009	11
12	Employee Benefits and Payroll Taxes			102,190	102,190		102,190	12
13	Insurance-Property, Liability and Malpractice			22,262	22,262		22,262	13
14	Other (specify):			62,633	62,633		62,633	14
15	<b>TOTAL General Administration</b>	<b>67,620</b>	<b>11,738</b>	<b>335,393</b>	<b>414,751</b>	<b>(13,741)</b>	<b>401,010</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>331,337</b>	<b>121,887</b>	<b>440,961</b>	<b>894,185</b>	<b>(21,041)</b>	<b>873,144</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			344,952	344,952		344,952	17
18	Interest			412,185	412,185		412,185	18
19	Real Estate Taxes			46,860	46,860		46,860	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			9,751	9,751		9,751	22
23	<b>TOTAL Ownership</b>			<b>813,748</b>	<b>813,748</b>		<b>813,748</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>331,337</b>	<b>121,887</b>	<b>1,254,709</b>	<b>1,707,933</b>	<b>(21,041)</b>	<b>1,686,892</b>	<b>24</b>

Facility Name: PRAIRIE LIVING WEST, LLC

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		17.87	2
3	Certified Nurse Assistants	5	10.00	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	9.29	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 1	9
10	Housekeepers	1	8.95	10
11	Laundry			11
12	Managers	2	18.72	12
13	Other Administrative	1	19.85	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>12</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	\$ 58,586 1
2		
		<b>Total</b> \$ 58,586 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
CARBONDALE SLF		CARBONDALE	

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: PRAIRIE LIVING WEST, LLC

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land 412,032 Year land was acquired 2009

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	50			2010	\$ 5,360,377	\$ 194,904	27.5	\$ 194,923	\$ 19	\$ 852,729	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	LAND IMPROVEMENTS				409,950	27,348	15	27,330	(18)	122,664	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)				\$ 5,770,327	\$ 222,252		\$ 222,253	\$ 1	\$ 975,393	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	\$ 613,543	\$ 122,700	\$ 122,709	9	5	\$ 550,882	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 613,543	\$ 122,700	\$ 122,709	9		\$ 550,882	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: PRAIRIE LIVING WEST, LLC

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	Name of Lender	2		3	4	6		7	8	9	
			Related**	YES			NO	Purpose of Loan				
			YES	NO			Original	Balance				
		<b>A. Directly Facility Related</b>										
		<b>Long-Term</b>										
1		PEOPLES NATIONAL BAN		X	FIRST MORTGAGE	10/09/09	\$ 6,210,000	\$ 6,086,630	10/09/34	.0675	\$ 412,184.66	1
2						/ /	\$	\$	/ /		\$	2
3						/ /	\$	\$	/ /		\$	3
		<b>Working Capital</b>										
4						/ /	\$	\$	/ /		\$	4
5						/ /	\$	\$	/ /		\$	5
6						/ /	\$	\$	/ /		\$	6
7		<b>TOTAL Facility Related</b>					\$ 6,210,000	\$ 6,086,630			\$ 412,185	7
		<b>B. Non-Facility Related</b>										
8						/ /	\$	\$	/ /		\$	8
9						/ /	\$	\$	/ /		\$	9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 6,210,000	\$ 6,086,630			\$ 412,185	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: PRAIRIE LIVING WEST, LLC

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	\$ 96,818	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	168,908 (35,024)		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,711		6
7	Other Prepaid Expenses	500		7
8	Accounts Receivable (owners or related parties)	16,181		8
9	Other(specify):	16,266		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 271,360	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	412,032		13
14	Buildings, at Historical Cost	5,360,377		14
15	Leasehold Improvements, at Historical Cost	409,950		15
16	Equipment, at Historical Cost	613,543		16
17	Accumulated Depreciation (book methods)	(1,526,275)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	129,098		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(16,395)		20
21	Restricted Funds	434,809		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>	\$ 5,817,138	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,088,498	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 3,125	\$	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	45,926		31
32	Accrued Interest Payable	24,763		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	See Attachment	15,188		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 89,002	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,086,630		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>	\$ 6,086,630	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 6,175,631	\$	45
46	<b>TOTAL EQUITY</b>	\$ (87,133)	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 6,088,498	\$	47

\*(See instructions.)

Facility Name: PRAIRIE LIVING WEST, LLC

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	\$ 1,458,701	1
2	Discounts and Allowances	(17,713)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 1,440,988</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services	26,562	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	5,648	8
9	Non-Resident Meals	779	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 32,989</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	2,141	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 2,141</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16	Insurance Adjustments	1,551	16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 1,551</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 1,477,669</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	321,935	19
20	Health Care/ Personal Care	157,499	20
21	General Administration	414,751	21
<b>B. Capital Expense</b>			
22	Ownership	813,748	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>\$ 1,707,933</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (230,264)</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>\$ (230,264)</b>	<b>31</b>

## Expenses PG 3 Other

General Services Detail		Amt
5200-5124-0-0	Exterminating	693
5200-5127-0-0	Rubbish Removal	2,043
5300-5140-0-0	Security & Monitoring	4,192
5200-5130-0-0	Vehicle Expense	1,469
5200-5131-0-0	Transportation Service	215
5200-5132-0-0	Water Softener	-
5200-5133-0-0	Window Washing	-
5200-5137-0-0	Miscellaneous Oper Expense	-

8,612

General Administration Detail		Amt
5160-5060-0-0	Consulting	18,734
5160-5063-0-0	Legal	2,235
5160-5064-0-0	Accounting	117
5160-5066-0-0	Audit	10,960
5160-5067-0-0	Contract Labor-Serv Prov	-
5160-5068-0-0	Contract Labor	672
5180-9999-0-0	Total Bad Debt	29,916

62,633



	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	53
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	-
9200-9212-0-0	Debt Write-Off	-
9300-9301-0-0	Partnership Management Fee	-
9300-9302-0-0	Asset Management Fee	-
9300-9303-0-0	Incentive Management	-
9300-9303-1-0	Incentive Asset Mgmt Fee	-
9300-9304-0-0	Tax Credit Fees & Incentive Fee	-
9300-9305-0-0	Organizational Expense	-
9300-9306-0-0	Developer Fees	-
9300-9307-0-0	Closing Costs	-
9700-9702-0-0	Amortization Expense	3,712
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	1,922
9900-9906-0-0	Property Damage Loss	4,065
9900-9907-0-0	Abandonment Loss	-
9900-9908-0-0	Grant Income	-
9900-9909-0-0	Misc: Title, Recording, Transfer	-
		9,751



Balance Sheet

Other Current Assets Detail		Amt	Current Liabilities Detail		Amt
1102-9970-0-0	A/R-Medicaid Food Stamps	186	2112-0100-0-0	Accrued Asset Management Fee	-
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	-
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	3,043
1102-9976-0-0	A/R-Other	16,080	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	2,071
			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	10,074
			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	-
		16,266			15,188

