

FOR BHF USE					

LL2

Supportive Living Facility

**2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2015)**

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>1000031</u></p> <p>Facility Name: <u>CAMBRIDGE HOUSE OF OFALLON</u></p> <p>Address: <u>844 CAMBRIDGE BLVD</u> <u>OFALLON</u> <u>62269</u> <small>Number City Zip Code</small></p> <p>County: <u>ST CLAIR</u></p> <p>Telephone Number: (<u>618</u>) <u>624-9900</u> Fax # <u>618 624-9904</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>04/16/2004</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>Thomas Staszak</u> Telephone Number: <u>(815) 935-1992</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>01/01/2015</u> to <u>12/31/2015</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 style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>David J. Mitchell</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Title) <u>CFO, Gardant Management Solutions</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(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, Gardant Management Solutions</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 CAMBRIDGE HOUSE OF OFALLON

Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	100	Single Unit Apartment	100	36,500	1
2	3	Double Unit Apartment	3	1,095	2
3		Other			3
4	103	TOTALS	103	37,595	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	27,135	9,167		36,302	5
6	Double Unit					6
7	Other					7
8	TOTALS	27,135	9,167		36,302	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.56%

D. Indicate the number of paid bed-hold days the SLF had during this year 763 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: 2015 Fiscal Year: 2015

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? YES If yes, did the facility make all of the required payments of interest and principle? Yes
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: CAMBRIDGE HOUSE OF OFALLON

Report Period Beginning:

01/01/2015

Ending: 12/31/2015

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	262,819	193,261	1,563	457,643		457,643	1
2	Housekeeping, Laundry and Maintenance	100,761	28,327	61,823	190,911		190,911	2
3	Heat and Other Utilities			149,707	149,707	(25,749)	123,958	3
4	Other (specify): See Page 3 Attachment			25,014	25,014		25,014	4
5	TOTAL General Services	363,580	221,588	238,107	823,275	(25,749)	797,526	5
B. Health Care and Programs								
6	Health Care/ Personal Care	451,466	8,063		459,529		459,529	6
7	Activities and Social Services	32,433	5,373		37,806		37,806	7
8	Other (specify): See Attachment							8
9	TOTAL Health Care and Programs	483,899	13,436		497,335		497,335	9
C. General Administration								
10	Administrative and Clerical	168,947	36,138	338,971	544,056	(38,882)	505,174	10
11	Marketing Materials, Promotions and Advertising	34,844	8,803	42,541	86,188		86,188	11
12	Employee Benefits and Payroll Taxes			264,693	264,693		264,693	12
13	Insurance-Property, Liability and Malpractice			81,922	81,922		81,922	13
14	Other (specify): See Page 3 Attachment			1,602	1,602		1,602	14
15	TOTAL General Administration	203,791	44,941	729,729	978,461	(38,882)	939,579	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,051,270	279,965	967,835	2,299,070	(64,631)	2,234,440	16
Capital Expenses								
D. Ownership								
17	Depreciation			324,073	324,073		324,073	17
18	Interest			405,371	405,371		405,371	18
19	Real Estate Taxes			66,571	66,571		66,571	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): See Page 3 Attachment			522,445	522,445		522,445	22
23	TOTAL Ownership			1,318,460	1,318,460		1,318,460	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,051,270	279,965	2,286,295	3,617,530	(64,631)	3,552,900	24

Facility Name: CAMBRIDGE HOUSE OF OFALLON

Report Period Beginning 01/01/2015 Ending: 12/31/2015

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 12	1
2	Licensed Practical Nurses	1	20.25	2
3	Certified Nurse Assistants	17	10.12	3
4	Activity Director & Assistants	Inc line 12	Inc line 12	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	11	10.27	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	9.21	10
11	Laundry			11
12	Managers	5	23.55	12
13	Other Administrative	4	20.84	13
14	Clerical	Inc line 13	Inc line 13	14
15	Marketing	Inc line 12	Inc line 12	15
16	Other			16
17	Total (lines 1 thru 16)	41	\$	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	Gardant Management Solutions	\$ 216,516	1
2			2
Total		\$ 216,516	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
CAMBRIDGE HOUSE OF MARYVILLE		MARYVILLE	
CAMBRIDGE HOUSE OF SWANSEA		SWANSEA	

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: CAMBRIDGE HOUSE OF OFALLON

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VIII. OWNERSHIP COSTS

A. Purchase price of land 1,028,000 Year land was acquired 2002

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	103			2003	\$ 8,086,895	\$ 294,069	28	\$ 288,818	\$ (5,251)	\$ 3,565,586	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Leasehold Improvements			229,973	15,332	15	15,332	(0)	185,896	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)				\$ 8,316,868	\$ 309,401		\$ 304,149	\$ (5,252)	\$ 3,751,482	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	\$ 822,073	\$ 14,672	\$ 164,415	\$ 149,743	5	\$ 660,488	18
19	Vehicles				\$			19
20	TOTAL (lines 18 and 19)	\$ 822,073	\$ 14,672	\$ 164,415	149,743		\$ 660,488	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: CAMBRIDGE HOUSE OF OFALLON

Report Period Beginning: 01/01/2015

Ending: 2/31/2015

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	12/01/03	\$ 7,470,000	\$ 6,738,863	08/01/44	.0598	\$ 405,371
2					/ /			/ /	.0000	\$
3					/ /			/ /	.0000	\$
4					/ /			/ /	.0000	\$
5									.0000	\$
	Working Capital									
6					/ /				.0000	\$
7	TOTAL Facility Related					\$ 7,470,000	\$ 6,738,863			\$ 405,371
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 7,470,000	\$ 6,738,863			\$ 405,371

* 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: CAMBRIDGE HOUSE OF OFALLON

Report Period Beginning: 01/01/2015

Ending:

12/31/2015

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,877,430	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (40,548))	478,621		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,763		6
7	Other Prepaid Expenses	17,010		7
8	Accounts Receivable (owners or related parties)	3,248		8
9	Other(specify): See Page 7 Attachment	6,026		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,451,098	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,028,000		13
14	Buildings, at Historical Cost	8,086,895		14
15	Leasehold Improvements, at Historical Cost	229,973		15
16	Equipment, at Historical Cost	822,073		16
17	Accumulated Depreciation (book methods)	(4,411,970)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	408,681		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(281,730)		20
21	Restricted Funds	1,485,190		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,367,112	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,818,209	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 41,738	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,789		30
31	Accrued Taxes Payable	67,448		31
32	Accrued Interest Payable	34,986		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	513,282		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 682,243	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,738,863		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)	\$ 6,738,863	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,421,106	\$	45
46	TOTAL EQUITY	\$ 2,397,103	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,818,209	\$	47

*(See instructions.)

Facility Name: CAMBRIDGE HOUSE OF OFALLON

Report Period Beginning: 01/01/2015

Ending:

12/31/2015

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	\$ 3,437,783	1
2	Discounts and Allowances	(24,130)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,413,653	3
B. Other Operating Revenue			
4	Special Services	148,048	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	19,985	8
9	Non-Resident Meals	6,336	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 174,369	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	3,898	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 3,898	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	11,919	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 11,919	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,603,839	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	823,275	19
20	Health Care/ Personal Care	497,335	20
21	General Administration	978,461	21
B. Capital Expense			
22	Ownership	1,318,460	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)	\$ 3,617,530	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (13,692)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (13,692)	31

Expenses PG

	General Services Other	
5200-5000-0-0	Operating Allocation	-
5200-5124-0-0	Exterminating	1,469
5200-5127-0-0	Rubbish Removal	5,301
5200-5130-0-0	Vehicle Expense	5,220
5200-5131-0-0	Transportation Service	-
5300-5140-0-0	Security & Monitoring	13,024

Health Care & Programs

- 5160-5060-0-0
- 5160-5063-0-0
- 5160-5064-0-0
- 5160-5066-0-0
- 5160-5067-0-0
- 5160-5068-0-0
- 5190-5000-0-0
- 5180-5079-0-0
- 5180-5079-1-0
- 5180-5080-0-0
- 5180-5081-0-0
- 5180-5081-1-0
- 5180-5082-0-0

25,014

-

3 Other

General Administration Other	Amt		Ownership Other	Amt
Consulting	-	9100-9101-0-0	Interest & Dividend Income	-
Legal	1,168	9100-9102-0-0	Assessment Income	-
Accounting	110	9100-9103-0-0	Assessment Expense	-
Audit	13,730	9200-9202-0-0	Financing Fees	4,530
Contract Labor-Serv Prov	-	9200-9204-0-0	Mortgage Service Fee	16,947
Contract Labor	1,261	9200-9205-0-0	Mortgage Insurance Prem	33,709
Other Admin Allocation	0	9200-9206-0-0	Participation Fee	-
Bad Debt - Resident	27	9200-9207-0-0	Letter of Credit Fee	-
Bad Debt - Resident - Recovery	(571)	9200-9208-0-0	Bond & Draw Fee	-
Bad Debt - Resident Prior Period	-	9200-9209-0-0	Remarketing and Trustee Fee	-
Bad Debt - Medicaid Pending Deni	(10,906)	9200-9210-0-0	Interest Expense-Note	-
Bad Debt - Medicaid Pending - Rec	(3,217)	9200-9211-0-0	Interest Expense-LP	-
Bad Debt - Medicaid Denial Prior F	-	9200-9212-0-0	Debt Write-Off	-
		9300-9301-0-0	Partnership Management Fee	25,000
		9300-9302-0-0	Asset Management Fee	5,004
		9300-9303-0-0	Incentive Management	432,062
		9300-9303-1-0	Incentive Asset Mgmt Fee	-
		9300-9304-0-0	Tax Credit Fees & Incentive Fee	645
		9300-9305-0-0	Organizational Expense	-
		9300-9306-0-0	Developer Fees	-
		9300-9307-0-0	Closing Costs	-
		9700-9702-0-0	Amortization Expense	4,548
		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	-

1,602

522,445

Balance Sheet Page 7 Other, See Attachment

Other Current Assets Detail		Amt	Current Liabilities Detail		Amt
1102-9971-0-0	A/R-Employee Advance	-	2112-0100-0-0	Accrued Asset Management Fee	5,004
1102-9972-0-0	A/R-Gardant Mgmt Solutions	-	2112-0101-0-0	Accrued Partnership Mgmt Fee	25,000
1102-9973-0-0	A/R-Insurance Reimbursement	-	2112-0102-0-0	Accrued Incentive Mgmt Fee	454,403
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	18,066
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	-
1105-0006-0-0	Security Deposit-Equip & Util	6,026	2112-0130-0-0	Accrued MIP	-
1105-0009-0-0	Transfer Account	-	2112-0140-0-0	Accrued Vacation	-
1105-0012-0-0	Undeposited Funds	-	2112-0146-0-0	Payroll Benefits	-
			2112-0150-0-0	Security Deposits	-
			2112-0154-0-0	Unclaimed Property	1,579
			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	9,229
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
			2111-0040-0-0	Construction Account Payable	-
		6,026	2112-0140-0-0	Accrued Vacation	0
			2112-0144-0-0	Payroll Union Dues	0
					513,282
Other Long Term Assets Detail					
1201-0020-0-0	CIP	-			
1201-0021-0-0	CIP- Land Option Addition	-			
1201-0022-0-0	CIP- Other Addition	-			
		-			

Income Statement Page 8 Other, See Attachment

Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	425
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	11,494
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		11,919

