

		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>1000115</u></p> <p>Facility Name: <u>HERITAGE WOODS OF BOLINGBRK</u></p> <p>Address: <u>550 KILDEER</u> <u>BOLINGBROOK</u> <u>60440</u> <small>Number City Zip Code</small></p> <p>County: _____</p> <p>Telephone Number: (<u>##</u>) <u>783-9640</u> Fax # <u>630 783-9648</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>02/27/2009</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>Vicky Gray</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>0 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 align="center">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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	(Telephone) () _____ Fax # () _____																																													

Facility Name: SENIOR ESTATES SUPPORTIVE LIVING FACILIT

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	235,646	195,100	2,263	433,009		433,009	1
2	Housekeeping, Laundry and Maintenance	115,925	28,769	45,064	189,758		189,758	2
3	Heat and Other Utilities			171,812	171,812	(29,021)	142,791	3
4	Other (specify):			31,206	31,206		31,206	4
5	TOTAL General Services	351,571	223,869	250,345	825,785	(29,021)	796,764	5
B. Health Care and Programs								
6	Health Care/ Personal Care	454,277	8,903		463,180		463,180	6
7	Activities and Social Services	28,257	3,460		31,717		31,717	7
8	Other (specify): page 3 att							8
9	TOTAL Health Care and Programs	482,534	12,363		494,897		494,897	9
C. General Administration								
10	Administrative and Clerical	176,175	37,393	287,559	501,127	(27,659)	473,468	10
11	Marketing Materials, Promotions and Advertising	54,343	7,694	36,522	98,559		98,559	11
12	Employee Benefits and Payroll Taxes			228,160	228,160		228,160	12
13	Insurance-Property, Liability and Malpractice			43,773	43,773		43,773	13
14	Other (specify):			102,770	102,770		102,770	14
15	TOTAL General Administration	230,518	45,087	698,784	974,389	(27,659)	946,730	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,064,623	281,319	949,129	2,295,071	(56,680)	2,238,391	16
Capital Expenses								
D. Ownership								
17	Depreciation			490,029	490,029		490,029	17
18	Interest			798,583	798,583		798,583	18
19	Real Estate Taxes			101,503	101,503		101,503	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): See Attachment 2			599,582	599,582		599,582	22
23	TOTAL Ownership			1,989,697	1,989,697		1,989,697	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,064,623	281,319	2,938,826	4,284,768	(56,680)	4,228,088	24

Facility Name: **SENIOR ESTATES SUPPORTIVE LIVING FACILITY LIMITED PAR**

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	2	21.72	2
3	Certified Nurse Assistants	14	11.15	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	10	9.32	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	9.86	10
11	Laundry			11
12	Managers	5	23.68	12
13	Other Administrative	4	23.76	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)	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

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? \$ _____

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: SENIOR ESTATES SUPPORTIVE LIVING FACILITY LHM

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	\$ 455,603	28	\$ 455,602	\$ (0)	\$ 3,147,105	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Leasehold Improvements				242,571	16,171	15	16,171	0	111,852	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	\$ 471,774		\$ 471,774	\$ 0	\$ 3,258,957	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	\$ 18,255	\$ 142,565	124,310	5	\$ 684,112	18
19	Vehicles				\$			19
20	TOTAL (lines 18 and 19)	\$ 712,825	\$ 18,255	\$ 142,565	124,310		\$ 684,112	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: SENIOR ESTATES SUPPORTIVE LIVING FACILITY LIMITE

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	AMALGAMATED BANK		X	FIRST MORTGAGE / BOND	12/01/07	\$ 11,900,000	\$ 11,280,000	12/01/42	.0700	\$ 798,583
2					/ /			/ /	.0000	\$
3					/ /			/ /	.0000	\$
4									.0000	\$
5					/ /			/ /	.0000	\$
	Working Capital									
6					/ /			/ /	.0000	\$
7	TOTAL Facility Related					\$ 11,900,000	\$ 11,280,000			\$ 798,583
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 11,900,000	\$ 11,280,000			\$ 798,583

* 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: **SENIOR ESTATES SUPPORTIVE LIVING FACILITY LIMITED I**

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	\$ 313,905	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (54,375))	601,212		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,026		6
7	Other Prepaid Expenses	1,444		7
8	Accounts Receivable (owners or related parties)	14,244		8
9	Other(specify): <u>page 7 att</u>	472		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 945,303	\$	10
	B. Long-Term Assets			
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)	(3,943,069)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	544,440		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(119,113)		20
21	Restricted Funds	2,009,864		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,792,129	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,737,432	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 116,538	\$	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	103,403		31
32	Accrued Interest Payable	65,800		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>See Attachment</u>	624,340		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 910,082	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,280,000		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)	\$ 11,280,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 12,190,082	\$	45
46	TOTAL EQUITY	\$ 1,547,350	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 13,737,432	\$	47

*(See instructions.)

Facility Name: SENIOR ESTATES SUPPORTIVE LIVING FACILITY

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	\$ 3,850,041	1
2	Discounts and Allowances	(1,236)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,848,805	3
B. Other Operating Revenue			
4	Special Services	145,700	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	8,282	8
9	Non-Resident Meals	3,892	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 157,874	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	235	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 235	14
D. Other Revenue (page 8 att):			
15		7,628	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 7,628	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,014,542	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	825,785	19
20	Health Care/ Personal Care	494,897	20
21	General Administration	974,389	21
B. Capital Expense			
22	Ownership	1,989,697	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)	\$ 4,284,768	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (270,226)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (270,226)	31

Expenses PG

	General Services Other	
5200-5000-0-0	Operating Allocation	-
5200-5124-0-0	Exterminating	2,380
5200-5127-0-0	Rubbish Removal	3,793
5200-5130-0-0	Vehicle Expense	1,603
5200-5131-0-0	Transportation Service	-
5300-5140-0-0	Security & Monitoring	23,430

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

31,206

-

3 Other

General Administration Other	Amt		Ownership Other	Amt
Consulting	25,000	9100-9101-0-0	Interest & Dividend Income	-
Legal	6,203	9100-9102-0-0	Assessment Income	-
Accounting	110	9100-9103-0-0	Assessment Expense	-
Audit	11,830	9200-9202-0-0	Financing Fees	-
Contract Labor-Serv Prov	-	9200-9203-1-0	Mortgage Interest Premium	-
Contract Labor	20,149	9200-9204-0-0	Mortgage Service Fee	-
Other Admin Allocation	0	9200-9205-0-0	Mortgage Insurance Prem	-
Bad Debt - Resident	12,010	9200-9206-0-0	Participation Fee	-
Bad Debt - Resident - Recovery	(218)	9200-9207-0-0	Letter of Credit Fee	-
Bad Debt - Resident Prior Period	-	9200-9208-0-0	Bond & Draw Fee	-
Bad Debt - Medicaid Pending Deni	27,685	9200-9209-0-0	Remarketing and Trustee Fee	4,064
Bad Debt - Medicaid Pending - Rec	-	9200-9210-0-0	Interest Expense-Note	-
Bad Debt - Medicaid Denial Prior F	-	9200-9211-0-0	Interest Expense-LP	-
		9200-9212-0-0	Debt Write-Off	-
		9300-9301-0-0	Partnership Management Fee	-
		9300-9302-0-0	Asset Management Fee	17,911
		9300-9303-0-0	Incentive Management	528,688
		9300-9303-1-0	Incentive Asset Mgmt Fee	31,103
		9300-9304-0-0	Tax Credit Fees & Incentive Fee	623
		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	-
		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

-

102,770

599,582

Balance Sheet

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	17,911
1102-9972-0-0	A/R-Gardant Mgmt Solutions	-	2112-0101-0-0	Accrued Partnership Mgmt Fee	-
1102-9973-0-0	A/R-Insurance Reimbursement	-	2112-0102-0-0	Accrued Incentive Mgmt Fee	528,688
1102-9974-0-0	A/R-Subscription Receivable	-	2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	31,103
1102-9975-0-0	A/R-CIP	-	2112-0105-0-0	Accrued Liabilities	24,421
1102-9976-0-0	A/R-Other	136	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	336	2112-0130-0-0	Accrued MIP	-
1105-0009-0-0	Transfer Account	-	2112-0146-0-0	Payroll Benefits	-
1105-0012-0-0	Undeposited Funds	-	2112-0154-0-0	Unclaimed Property	9,823
			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	12,394
			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	-
			2112-0140-0-0	Accrued Vacation	0
			2112-0144-0-0	Payroll Union Dues	0
		472			624,340
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

Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	1,607
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	3,600
3300-3393-0-0	Insurance Adjustments	2,421
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		7,628

