

		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><b>I. Facility ID Number:</b> <u>1000140</u></p> <p><b>Facility Name:</b> <u>HERITAGE WOODS OF GURNEE LLC</u></p> <p><b>Address:</b> <u>3775 GRAND AVENUE</u> <u>GURNEE</u> <u>60031</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>LAKE</u></p> <p><b>Telephone Number:</b> ( <u>847</u> ) <u>623-6300</u> Fax # <u>847 623-6305</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>10/18/2012</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>Thomas Staszak</u> <b>Telephone Number:</b> <u>(815) 935-1992</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><b>0</b> 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;"><b>Officer or Administrator of Provider</b></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;"><b>Paid Preparer</b></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 &amp; 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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>David J. Mitchell</u>			(Title) <u>CFO, Gardant Management Solutions</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) ( ) _____ Fax # ( ) _____	
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Facility Name Gurnee Supportive Living Limited Partnership

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	
		Gurnee Supportive Living Limited Partnership			
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	27,838	8,536		36,374	5
6	Double Unit					6
7	Other					7
8	TOTALS	27,838	8,536		36,374	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.)       94.91%      

**D. Indicate the number of paid bed-hold days the SLF had during this year**       609       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?**       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: Gurnee Supportive Living Limited Partnership

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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	260,740	191,047	1,839	453,626		453,626	1
2	Housekeeping, Laundry and Maintenance	93,311	44,610	74,531	212,452		212,452	2
3	Heat and Other Utilities			145,416	145,416	(27,039)	118,377	3
4	Other (specify): See Attachment pg 3			35,760	35,760		35,760	4
5	<b>TOTAL Gener Gurnee Supportive Living Limited Part</b>	354,051	235,657	257,546	847,254	(27,039)	820,215	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	492,456	8,306		500,762		500,762	6
7	Activities and Social Services	30,901	4,455		35,356		35,356	7
8	Other (specify): See Attachment							8
9	<b>TOTAL Health Care and Programs</b>	523,357	12,761		536,118		536,118	9
<b>C. General Administration</b>								
10	Administrative and Clerical	210,839	38,274	311,385	560,498	(26,940)	533,558	10
11	Marketing Materials, Promotions and Advertising	62,186	6,540	24,821	93,547		93,547	11
12	Employee Benefits and Payroll Taxes			316,920	316,920		316,920	12
13	Insurance-Property, Liability and Malpractice			66,505	66,505		66,505	13
14	Other (specify): See Attachment pg 3			243,728	243,728		243,728	14
15	<b>TOTAL General Administration</b>	273,025	44,814	963,359	1,281,198	(26,940)	1,254,259	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	1,150,433	293,232	1,220,905	2,664,570	(53,979)	2,610,592	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			767,442	767,442		767,442	17
18	Interest			501,021	501,021		501,021	18
19	Real Estate Taxes			130,622	130,622		130,622	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): See Attachment pg 3			633,126	633,126		633,126	22
23	<b>TOTAL Ownership</b>			2,032,211	2,032,211		2,032,211	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	1,150,433	293,232	3,253,116	4,696,781	(53,979)	4,642,802	24

Facility Name: **Gurnee Supportive Living Limited Partnership**

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	20.87	2
3	Certified Nurse Assistants	16	11.06	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 <b>Gurnee Support</b>	11	9.86	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	8.97	10
11	Laundry			11
12	Managers	5	23.11	12
13	Other Administrative	6	20.74	13
14	Clerical	Inc line 13	Inc line 13	14
15	Marketing	Inc line 12	Inc line 12	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	42	\$	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
<b>Total</b>				\$	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? \$ \_\_\_\_\_  
 (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).

**VI. (B) Management fees paid to unrelated parties**

**Amount of Fee**

1	Gardant Management Solutions	\$ 194,312	1
2			2
<b>Total</b>		\$ 194,312	3

Facility Name: Gurnee Supportive Living Limited Partnership

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VIII. OWNERSHIP COSTS

A. Purchase price of land 1,233,458 Year land was acquired 2008

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			2008	\$ 14,720,586	\$ 535,294	28	\$ 525,735	\$ (9,559)	\$ 1,739,511	1
2											2
3											3
4											4
5											5
Improv. Gurnee Supportive Living Limited Partnership											
6	Leasehold Improvements				534,376	35,625	15	35,625	0	115,737	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)				\$ 15,254,962	\$ 570,919		\$ 561,360	\$ (9,559)	\$ 1,855,249	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	\$ 982,614	\$ 196,523	\$ 196,523	(0)	5	\$ 636,104	18
19	Vehicles				\$			19
20	TOTAL (lines 18 and 19)	\$ 982,614	\$ 196,523	\$ 196,523	(0)		\$ 636,104	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: Gurnee Supportive Living Limited Partnership

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 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions	Gurnee Supportive Living		/ /				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 Related**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1	CENTENNIAL MORTGAGE		X	FIRST MORTGAGE	08/01/11	\$ 11,550,000	\$ 11,204,758	11/01/52	4.4500	\$ 501,021	1
2					/ /			/ /	.0000	\$	2
3					/ /			/ /	.0000	\$	3
4					/ /			/ /	.0000	\$	4
5									.0000	\$	5
	<b>Working Capital</b>										
6					/ /				.0000	\$	6
7	<b>TOTAL Facility Related</b>					\$ 11,550,000	\$ 11,204,758			\$ 501,021	7
	<b>B. Non-Facility Related</b>										
8					/ /			/ /			8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 11,550,000	\$ 11,204,758			\$ 501,021	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: Gurnee Supportive Living Limited Partnership

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 831,807	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (239,524) )	603,080		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance Gurnee Supportive Living	62,980		6
7	Other Prepaid Expenses	9,033		7
8	Accounts Receivable (owners or related parties)	18,892		8
9	Other(specify): pg 7	261		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,526,054	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,233,458		13
14	Buildings, at Historical Cost	14,720,586		14
15	Leasehold Improvements, at Historical Cost	534,376		15
16	Equipment, at Historical Cost	982,614		16
17	Accumulated Depreciation (book methods)	(2,491,353)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	526,460		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(70,766)		20
21	Restricted Funds	1,191,818		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): pg 7			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 16,627,194	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 18,153,247	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 227,410	\$	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	131,291		31
32	Accrued Interest Payable	41,551		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	See Attachment pg 7	579,206		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 979,458	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,204,758		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>	\$ 11,204,758	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 12,184,216	\$	45
46	<b>TOTAL EQUITY</b>	\$ 5,969,031	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 18,153,247	\$	47

\*(See instructions.)

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	\$ 3,928,759	1
2	Discounts and Allowances	(9,295)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 3,919,464</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services	102,441	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	8,735	8
9	Non-Resident Meals	3,907	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 115,083</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	2,981	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 2,981</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	See Attachment	8,406	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 8,406</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 4,045,934</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	847,254	19
20	Health Care/ Personal Care	536,118	20
21	General Administration	1,281,198	21
<b>B. Capital Expense</b>			
22	Ownership	2,032,211	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>\$ 4,696,781</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (650,847)</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>\$ (650,847)</b>	<b>31</b>

**Expenses PG**

	General Services Other		Health Care & Programs	
5200-5000-0-0	Operating Allocation	-		5160-5060-0-0
5200-5124-0-0	Exterminating	13,623		5160-5063-0-0
5200-5127-0-0	Rubbish Removal	6,714		5160-5064-0-0
5200-5130-0-0	Vehicle Expense	1,614		5160-5066-0-0
5200-5131-0-0	Transportation Service	29		5160-5067-0-0
5300-5140-0-0	Security & Monitoring	13,780		5160-5068-0-0
				5190-5000-0-0
			Gurnee Supportive Living Limited Partnership	5180-5079-0-0
				5180-5079-1-0
				5180-5080-0-0
				5180-5081-0-0
				5180-5081-1-0
				5180-5082-0-0

35,760

-

### 3 Other

General Administration Other	Amt		Ownership Other	Amt
Consulting	20,000	9100-9101-0-0	Interest & Dividend Income	-
Legal	35,369	9100-9102-0-0	Assessment Income	-
Accounting	70	9100-9103-0-0	Assessment Expense	-
Audit	9,595	9200-9202-0-0	Financing Fees	-
Contract Labor-Serv Prov	-	9200-9204-0-0	Mortgage Service Fee	-
Contract Labor	20,115	9200-9205-0-0	Mortgage Insurance Prem	50,664
Other Admin Allocation	0	9200-9206-0-0	Participation Fee	-
Bad Debt - Resident	167,906	9200-9207-0-0	Letter of Credit Fee	-
Bad Debt - Resident - Recovery	-	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	(9,326)	9200-9210-0-0	Interest Expense-Note	-
Bad Debt - Medicaid Pending - Rec	-	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	-
		9300-9302-0-0	Asset Management Fee	31,827
		9300-9303-0-0	Incentive Management	498,876
		9300-9303-1-0	Incentive Asset Mgmt Fee	29,349
		9300-9304-0-0	Tax Credit Fees & Incentive Fee	630
		9300-9305-0-0	Organizational Expense	-
		9300-9306-0-0	Developer Fees	-
		9300-9307-0-0	Closing Costs	-
		9700-9702-0-0	Amortization Expense	21,779
		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	-

243,728

633,126

Balance Sheet attachment page 7

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	31,827
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	426,056
1102-9974-0-0	A/R-Subscription Receivable	-	2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	25,065
1102-9975-0-0	A/R-CIP	-	2112-0105-0-0	Accrued Liabilities	23,245
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	261	2112-0130-0-0	Accrued MIP	-
1105-0009-0-0	Transfer Account	-	Gurnee Su  2112-0140-0-0	Accrued Vacation	-
1105-0012-0-0	Undeposited Funds	-	2112-0146-0-0	Payroll Benefits	-
			2112-0154-0-0	Unclaimed Property	-
			2112-0155-0-0	Reservation Deposit	1,500
			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	71,513
			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
		261	2112-0144-0-0	Payroll Union Dues	0
					579,206
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 attachment page 8

Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	4,582
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	3,823
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-

Gurnee Supportive Living Limited Partnership

8,406





