

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>1000096</u></p> <p><b>Facility Name:</b> <u>HERITAGE WOODS OF MOLINE</u></p> <p><b>Address:</b> <u>5500 46TH AVENUE DR</u> <u>MOLINE</u> <u>61265</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>ROCK ISLAND</u></p> <p><b>Telephone Number:</b> ( <u>309</u> ) <u>736-5655</u> Fax # <u>309 736-5651</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>11/17/2008</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>VICKY GRAY</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>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;"><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 HERITAGE WOODS OF MOLINE

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	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 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
5	Single Unit	24,585	10,431		35,016	5
6	Double Unit					6
7	Other					7
8	TOTALS	24,585	10,431		35,016	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.)     96.90%    

**D. Indicate the number of paid bed-hold days the SLF had during this year**     248     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: HERITAGE WOODS OF MOLINE

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	223,714	185,678	2,098	411,490		411,490	1
2	Housekeeping, Laundry and Maintenance	93,494	27,515	33,597	154,606		154,606	2
3	Heat and Other Utilities			110,431	110,431	(23,847)	86,584	3
4	Other (specify): See Attachment			33,853	33,853		33,853	4
5	<b>TOTAL General Services</b>	317,208	213,193	179,979	710,380	(23,847)	686,534	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	422,248	8,039		430,287		430,287	6
7	Activities and Social Services	28,620	2,433		31,053		31,053	7
8	Other (specify): See Attachment							8
9	<b>TOTAL Health Care and Programs</b>	450,868	10,472		461,340		461,340	9
<b>C. General Administration</b>								
10	Administrative and Clerical	160,962	38,750	276,937	476,649	(34,438)	442,211	10
11	Marketing Materials, Promotions and Advertising	43,902	10,070	69,202	123,174		123,174	11
12	Employee Benefits and Payroll Taxes			231,300	231,300		231,300	12
13	Insurance-Property, Liability and Malpractice			42,686	42,686		42,686	13
14	Other (specify): See Attachment			58,468	58,468		58,468	14
15	<b>TOTAL General Administration</b>	204,864	48,820	678,593	932,277	(34,438)	897,839	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	972,940	272,485	858,572	2,103,997	(58,284)	2,045,713	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			425,498	425,498		425,498	17
18	Interest			610,900	610,900		610,900	18
19	Real Estate Taxes			83,898	83,898		83,898	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): See Attachment			593,714	593,714		593,714	22
23	<b>TOTAL Ownership</b>			1,714,010	1,714,010		1,714,010	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	972,940	272,485	2,572,582	3,818,007	(58,284)	3,759,722	24

Facility Name: HERITAGE WOODS OF MOLINE

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	20.54	2
3	Certified Nurse Assistants	15	10.06	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	9	9.41	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	9.45	10
11	Laundry			11
12	Managers	5	20.70	12
13	Other Administrative	5	19.43	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>	<b>38</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	Gardant Management Solutions	\$ 183,549	1
2			2
<b>Total</b>		<b>\$ 183,549</b>	<b>3</b>

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:

01/01/2015

Ending:

12/31/2015

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	\$ 3,174,968	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Leasehold Improvements			265,361	15,656	15	17,691	2,034	147,223	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	\$ 424,210		\$ 426,245	\$ 2,034	\$ 3,322,192	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	\$ 630,227	\$ 1,288	\$ 126,045	124,757	5	\$ 625,078	18
19	Vehicles				\$			19
20	TOTAL (lines 18 and 19)	\$ 630,227	\$ 1,288	\$ 126,045	124,757		\$ 625,078	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: **01/01/2015**

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	<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	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			
	<b>A. Directly Facility Related</b>									
	<b>Long-Term</b>									
1	AMALGAMATED		X	FIRST MORTGAGE / BOND	12/14/06	\$ 10,870,000	\$ 10,035,000	12/01/41	.0600	\$ 610,900
2					/ /			/ /	.0000	\$
3					/ /			/ /	.0000	\$
4					/ /			/ /	.0000	\$
5					/ /			/ /	.0000	\$
	<b>Working Capital</b>									
6					/ /			/ /	.0000	\$
7	<b>TOTAL Facility Related</b>					\$ 10,870,000	\$ 10,035,000			\$ 610,900
	<b>B. Non-Facility Related</b>									
8					/ /			/ /		
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 10,870,000	\$ 10,035,000			\$ 610,900

\* 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: 01/01/2015

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	\$ 160,515	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (83,908) )	362,515		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,030		6
7	Other Prepaid Expenses	12,516		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	2,307		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 565,882	\$	10
	<b>B. Long-Term Assets</b>			
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	630,227		16
17	Accumulated Depreciation (book methods)	(3,947,270)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	544,051		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(150,728)		20
21	Restricted Funds	2,178,143		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>	\$ 10,913,055	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 11,478,938	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 29,215	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	21,791		30
31	Accrued Taxes Payable	88,488		31
32	Accrued Interest Payable	50,175		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	See Attachment	702,962		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 892,631	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	10,035,000		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>	\$ 10,035,000	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 10,927,631	\$	45
46	<b>TOTAL EQUITY</b>	\$ 551,306	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 11,478,938	\$	47

\*(See instructions.)

Facility Name: HERITAGE WOODS OF MOLINE

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	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 3,457,750	1
2	Discounts and Allowances	(13,904)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 3,443,846</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services	133,043	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	14,330	8
9	Non-Resident Meals	8,289	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 155,662</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	1,547	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 1,547</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	See Attachment	3,259	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 3,259</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 3,604,314</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	710,380	19
20	Health Care/ Personal Care	461,340	20
21	General Administration	932,277	21
<b>B. Capital Expense</b>			
22	Ownership	1,714,010	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>\$ 3,818,007</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (213,692)</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>\$ (213,692)</b>	<b>31</b>

**Expenses PG**

	General Services Other	
5200-5000-0-0	Operating Allocation	-
5200-5124-0-0	Exterminating	2,577
5200-5127-0-0	Rubbish Removal	17,571
5200-5130-0-0	Vehicle Expense	6,064
5200-5131-0-0	Transportation Service	-
5300-5140-0-0	Security & Monitoring	7,640

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

33,853

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### 3 Other

General Administration Other	Amt		Ownership Other	Amt
Consulting	61,400	9100-9101-0-0	Interest & Dividend Income	-
Legal	3,753	9100-9102-0-0	Assessment Income	-
Accounting	110	9100-9103-0-0	Assessment Expense	-
Audit	11,830	9200-9202-0-0	Financing Fees	1,000
Contract Labor-Serv Prov	-	9200-9204-0-0	Mortgage Service Fee	-
Contract Labor	4,895	9200-9205-0-0	Mortgage Insurance Prem	-
Other Admin Allocation	0	9200-9206-0-0	Participation Fee	-
Bad Debt - Resident	41,120	9200-9207-0-0	Letter of Credit Fee	-
Bad Debt - Resident - Recovery	(2,581)	9200-9208-0-0	Bond & Draw Fee	4,193
Bad Debt - Resident Prior Period	-	9200-9209-0-0	Remarketing and Trustee Fee	-
Bad Debt - Medicaid Pending Deni	(62,059)	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	50,000
		9300-9302-0-0	Asset Management Fee	5,004
		9300-9303-0-0	Incentive Management	513,292
		9300-9303-1-0	Incentive Asset Mgmt Fee	-
		9300-9304-0-0	Tax Credit Fees & Incentive Fee	593
		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	-

58,468

593,714

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	-
1102-9972-0-0	A/R-Gardant Mgmt Solutions	-	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	513,292
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	52,462
1102-9976-0-0	A/R-Other	443	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	1,864	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	732
			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	86,476
			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
		2,307			702,962
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	1,340
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	1,919
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		3,259





