

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>1000007</u></p> <p>Facility Name: <u>HERITAGE WOODS OF OTTAWA</u></p> <p>Address: <u>801 EAST ETNA ROAD</u> <u>OTTAWA</u> <u>61350</u> <small>Number City Zip Code</small></p> <p>County: <u>LASALLE</u></p> <p>Telephone Number: (<u>815</u>) <u>431-1400</u> Fax # <u>815 431-9147</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10/25/2007</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>VICKY GRAY</u> Telephone Number: <u>(815) 935-1992 EXT 229</u> 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 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 checked="" 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%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>David J. Mitchell</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO, Gardant Management Solutions</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) () _____ Fax # () _____</td> <td></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	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 DSI OTTAWA OPERATOR LLC

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	76	Single Unit Apartment	76	27,740	1
2	8	Double Unit Apartment	8	2,920	2
3		Other			3
4	84	TOTALS	84	30,660	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	15,200	14,691		29,891	5
6	Double Unit					6
7	Other					7
8	TOTALS	15,200	14,691		29,891	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.49%

D. Indicate the number of paid bed-hold days the SLF had during this year 103 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: DSI OTTAWA OPERATOR LLC

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	217,729	157,709	1,838	377,276		377,276	1
2	Housekeeping, Laundry and Maintenance	93,391	27,147	53,240	173,778		173,778	2
3	Heat and Other Utilities			104,119	104,119	(18,555)	85,564	3
4	Other (specify): See Attachment			17,366	17,366		17,366	4
5	TOTAL General Services	311,120	184,856	176,563	672,539	(18,555)	653,985	5
B. Health Care and Programs								
6	Health Care/ Personal Care	379,414	6,593		386,007		386,007	6
7	Activities and Social Services	21,741	4,056		25,797		25,797	7
8	Other (specify): See Attachment							8
9	TOTAL Health Care and Programs	401,155	10,649		411,804		411,804	9
C. General Administration								
10	Administrative and Clerical	100,407	30,332	220,073	350,812	(46,967)	303,845	10
11	Marketing Materials, Promotions and Advertising	43,824	5,159	36,145	85,128		85,128	11
12	Employee Benefits and Payroll Taxes			225,350	225,350		225,350	12
13	Insurance-Property, Liability and Malpractice			40,059	40,059		40,059	13
14	Other (specify): See Attachment			29,877	29,877		29,877	14
15	TOTAL General Administration	144,231	35,491	551,504	731,226	(46,967)	684,259	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	856,506	230,996	728,067	1,815,569	(65,522)	1,750,048	16
Capital Expenses								
D. Ownership								
17	Depreciation			278,207	278,207		278,207	17
18	Interest			213,557	213,557		213,557	18
19	Real Estate Taxes			94,180	94,180		94,180	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): See Attachment			211,510	211,510		211,510	22
23	TOTAL Ownership			797,454	797,454		797,454	23
24	GRAND TOTAL (Sum of lines 16 and 23)	856,506	230,996	1,525,521	2,613,023	(65,522)	2,547,501	24

Facility Name: DSI OTTAWA OPERATOR LLC

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	18.13	2
3	Certified Nurse Assistants	14	10.31	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	9.80	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	9.43	10
11	Laundry			11
12	Managers	5	19.47	12
13	Other Administrative	2	20.32	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)	34	\$	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
DSI FLORA OPERATOR & OWNER		FLORA	
DSI MANTENO OPERATOR & OWNER		MANTENO	
DSI WATSEKA OPERATOR & OWNER		WATSEKA	

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

	Name	Amount of Fee	
1	Gardant Management Solutions	\$ 149,697	1
2			2
Total		\$ 149,697	3

Facility Name: DSI OTTAWA OPERATOR LLC

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VIII. OWNERSHIP COSTS

A. Purchase price of land 518,552 Year land was acquired 1999

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	84			1999	\$ 6,485,626	\$ 237,356	28	\$ 235,841	\$ (1,515)	\$ 1,897,634	1
2											2
3											3
4											4
5											5
Improvement Type											
6											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)				\$ 6,485,626	\$ 237,356		\$ 235,841	\$ (1,515)	\$ 1,897,634	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	\$ 359,208	\$ 40,851	\$ 71841.6	30,991	5	\$ 307,616	18
19	Vehicles				\$			19
20	TOTAL (lines 18 and 19)	\$ 359,208	\$ 40,851	\$ 71,842	30,991		\$ 307,616	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: DSI OTTAWA OPERATOR LLC

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	MIDLAND STATES BANK		X	MORTGAGE	09/01/13	\$ 7,713,700	\$ 7,276,681	08/01/47	.0300	\$ 211,055
2					/ /			/ /	.0000	\$
3					/ /			/ /	.0000	\$
4					/ /			/ /	.0000	\$
5					/ /			/ /	.0000	\$
	Working Capital									
6	PEOPLES BANK		X	LINE OF CREDIT	1/9/15	460,000		1/7/2016	VARIABLE	\$ 2,501
7	TOTAL Facility Related					\$ 8,173,700	\$ 7,276,681			\$ 213,557
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 8,173,700	\$ 7,276,681			\$ 213,557

* 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: **DSI OTTAWA OPERATOR LLC**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	\$ 18,635	\$	1
2	Cash-Patient Deposits	7,976		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (15,505))	247,017		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,630		6
7	Other Prepaid Expenses	14,382		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	14,123		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 355,763	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	518,552		13
14	Buildings, at Historical Cost	6,485,626		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	359,208		16
17	Accumulated Depreciation (book methods)	(2,205,249)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,901,016		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(362,059)		20
21	Restricted Funds	209,574		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,906,667	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,262,430	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 23,649	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,198		30
31	Accrued Taxes Payable	100,080		31
32	Accrued Interest Payable	18,192		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Attachment	54,307		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 216,425	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,477,644		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)	\$ 7,477,644	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,694,070	\$	45
46	TOTAL EQUITY	\$ (431,639)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,262,430	\$	47

*(See instructions.)

Facility Name: DSI OTTAWA OPERATOR LLC

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	\$ 3,230,154	1
2	Discounts and Allowances	(14,135)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,216,019	3
B. Other Operating Revenue			
4	Special Services	101,016	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	24,526	8
9	Non-Resident Meals	3,932	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 129,474	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	968	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 968	14
D. Other Revenue (specify):			
15	See Attachment	4,120	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 4,120	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,350,581	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	672,539	19
20	Health Care/ Personal Care	411,804	20
21	General Administration	731,226	21
B. Capital Expense			
22	Ownership	797,454	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)	\$ 2,613,023	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 737,558	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 737,558	31

Expenses PG

	General Services Other	
5200-5000-0-0	Operating Allocation	-
5200-5124-0-0	Exterminating	3,186
5200-5127-0-0	Rubbish Removal	5,071
5200-5130-0-0	Vehicle Expense	-
5200-5131-0-0	Transportation Service	150
5300-5140-0-0	Security & Monitoring	8,959

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

17,366

-

3 Other

General Administration Other	Amt		Ownership Other	Amt
Consulting	300	9100-9101-0-0	Interest & Dividend Income	-
Legal	340	9100-9102-0-0	Assessment Income	-
Accounting	150	9100-9103-0-0	Assessment Expense	-
Audit	13,851	9200-9202-0-0	Financing Fees	-
Contract Labor-Serv Prov	-	9200-9204-0-0	Mortgage Service Fee	-
Contract Labor	1,261	9200-9205-0-0	Mortgage Insurance Prem	36,694
Other Admin Allocation	0	9200-9206-0-0	Participation Fee	-
Bad Debt - Resident	7,751	9200-9207-0-0	Letter of Credit Fee	-
Bad Debt - Resident - Recovery	(150)	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	6,375	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	-
		9300-9303-0-0	Incentive Management	-
		9300-9303-1-0	Incentive Asset Mgmt Fee	-
		9300-9304-0-0	Tax Credit Fees & Incentive Fee	-
		9300-9305-0-0	Organizational Expense	-
		9300-9306-0-0	Developer Fees	-
		9300-9307-0-0	Closing Costs	-
		9700-9702-0-0	Amortization Expense	164,816
		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	10,000
		9900-9907-0-0	Abandonment Loss	-
		9900-9908-0-0	Grant Income	-
		9900-9909-0-0	Misc: Title, Recording, Transfer	-

29,877

211,510

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	-
1102-9973-0-0	A/R-Insurance Reimbursement	12,580	2112-0102-0-0	Accrued Incentive Mgmt Fee	-
1102-9974-0-0	A/R-Subscription Receivable	-	2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
1102-9975-0-0	A/R-CIP	-	2112-0105-0-0	Accrued Liabilities	33,815
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	1,543	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 Deposit	5,575
			2112-0154-0-0	Unclaimed Property	151
			2112-0155-0-0	Reservation Deposit	2,800
			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	11,965
			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	-
		14,123	2112-0140-0-0	Accrued Vacation	0
			2112-0144-0-0	Payroll Union Dues	0
					54,307
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	226
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	3,894
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		4,120

