

		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>1000145</u></p> <p>Facility Name: <u>ST ANTHONY OF LANSING</u></p> <p>Address: <u>3025 SPRING LAKE DR</u> <u>LANSING</u> <u>60438</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: (<u>708</u>) <u>474-6100</u> Fax # <u>708 474-6102</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>08/21/2013</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</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%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>David J. Mitchell</u> (Title) <u>CFO, Gardant Management Solutions</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (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) _____ (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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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____																												

Facility Name ST ANTHONY OF LANSING

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	125	Single Unit Apartment	125	45,625	1
2		Double Unit Apartment			2
3		Other			3
4	125	TOTALS	125	45,625	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	37,482	5,384		42,866	5
6	Double Unit					6
7	Other					7
8	TOTALS	37,482	5,384		42,866	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.95%

D. Indicate the number of paid bed-hold days the SLF had during this year 1,117 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 158 (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: ST ANTHONY OF LANSING

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	279,209	233,364	1,836	514,409		514,409	1
2	Housekeeping, Laundry and Maintenance	100,292	27,768	47,114	175,174		175,174	2
3	Heat and Other Utilities			165,357	165,357	(28,651)	136,706	3
4	Other (specify): See Attachment			31,515	31,515		31,515	4
5	TOTAL General Services	379,501	261,132	245,822	886,455	(28,651)	857,804	5
B. Health Care and Programs								
6	Health Care/ Personal Care	531,465	10,502		541,967		541,967	6
7	Activities and Social Services	37,448	4,771		42,219		42,219	7
8	Other (specify): See Attachment							8
9	TOTAL Health Care and Programs	568,913	15,273		584,186		584,186	9
C. General Administration								
10	Administrative and Clerical	169,529	41,675	293,665	504,869	(32,500)	472,369	10
11	Marketing Materials, Promotions and Advertising	51,727	12,343	41,379	105,449		105,449	11
12	Employee Benefits and Payroll Taxes			273,282	273,282		273,282	12
13	Insurance-Property, Liability and Malpractice			76,167	76,167		76,167	13
14	Other (specify): See Attachment			338,730	338,730		338,730	14
15	TOTAL General Administration	221,256	54,018	1,023,223	1,298,497	(32,500)	1,265,997	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,169,670	330,423	1,269,045	2,769,138	(61,151)	2,707,987	16
Capital Expenses								
D. Ownership								
17	Depreciation			599,182	599,182		599,182	17
18	Interest			1,210,950	1,210,950		1,210,950	18
19	Real Estate Taxes			213,427	213,427		213,427	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): See Attachment			111,009	111,009		111,009	22
23	TOTAL Ownership			2,134,568	2,134,568		2,134,568	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,169,670	330,423	3,403,613	4,903,706	(61,151)	4,842,555	24

Facility Name: ST ANTHONY OF LANSING

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	23.93	2
3	Certified Nurse Assistants	17	10.80	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	12	9.59	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	8.87	10
11	Laundry			11
12	Managers	5	25.24	12
13	Other Administrative	4	20.30	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)	43	\$	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
DEER PATH SLF, LLC		HUNTLEY	

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: ST ANTHONY OF LANSING

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VIII. OWNERSHIP COSTS

A. Purchase price of land 2,558,268 Year land was acquired 2012

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	125			2013	\$ 17,631,220	\$ 440,781	40	\$ 440,781	\$ (0)	\$ 1,042,559	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Leasehold Improvements			327,005	16,350	20	16,350	0	38,703	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)				\$ 17,958,225	\$ 457,131		\$ 457,131	\$ (0)	\$ 1,081,262	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	\$ 1,424,914	\$ 142,051	\$ 284,983	142,932	5	\$ 333,473	18
19	Vehicles				\$			19
20	TOTAL (lines 18 and 19)	\$ 1,424,914	\$ 142,051	\$ 284,983	142,932		\$ 333,473	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: ST ANTHONY OF LANSING

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		X	FIRST MORTGAGE	07/13/12	\$ 18,630,000	\$ 18,630,000	12/01/32	.0650	\$ 1,210,950
2	COUNTY OF COOK		X	SECOND MORTGAGE	07/12/12	3,000,000	3,000,000	07/12/54	.0000	\$
3									.0000	\$
4									.0000	\$
5									.0000	\$
	Working Capital									
6					/ /				.0000	\$
7	TOTAL Facility Related					\$ 21,630,000	\$ 21,630,000			\$ 1,210,950
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 21,630,000	\$ 21,630,000			\$ 1,210,950

* 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: ST ANTHONY OF LANSING

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	\$ 394,252	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (376,486))	1,126,387		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,976		6
7	Other Prepaid Expenses	1,719		7
8	Accounts Receivable (owners or related parties)	11,322		8
9	Other(specify): SEE ATTACHMENT	4,542		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,558,197	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,558,268		13
14	Buildings, at Historical Cost	17,631,220		14
15	Leasehold Improvements, at Historical Cost	327,005		15
16	Equipment, at Historical Cost	1,424,914		16
17	Accumulated Depreciation (book methods)	(1,414,735)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,481,508		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(231,000)		20
21	Restricted Funds	1,130,650		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,907,830	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 24,466,027	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 115,310	\$	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	211,137		31
32	Accrued Interest Payable	100,913		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Attachment	635,018		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,062,377	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	21,630,000		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)	\$ 21,630,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 22,692,377	\$	45
46	TOTAL EQUITY	\$ 1,773,651	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 24,466,027	\$	47

*(See instructions.)

Facility Name: ST ANTHONY OF LANSING

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	\$ 4,428,298	1
2	Discounts and Allowances	(13,017)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,415,281	3
B. Other Operating Revenue			
4	Special Services	156,525	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	12,470	8
9	Non-Resident Meals	4,999	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 173,994	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	2,032	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,032	14
D. Other Revenue (specify):			
15	See Attachment	6,517	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 6,517	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,597,824	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	886,455	19
20	Health Care/ Personal Care	584,186	20
21	General Administration	1,298,497	21
B. Capital Expense			
22	Ownership	2,134,568	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)	\$ 4,903,706	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (305,883)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (305,883)	31

Expenses PG

	General Services Other	
5200-5000-0-0	Operating Allocation	-
5200-5124-0-0	Exterminating	9,055
5200-5127-0-0	Rubbish Removal	12,098
5200-5130-0-0	Vehicle Expense	1,318
5200-5131-0-0	Transportation Service	24
5300-5140-0-0	Security & Monitoring	9,020

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

31,515

-

3 Other

General Administration Other	Amt		Ownership Other	Amt
Consulting	13,500	9100-9101-0-0	Interest & Dividend Income	-
Legal	4,602	9100-9102-0-0	Assessment Income	-
Accounting	-	9100-9103-0-0	Assessment Expense	-
Audit	11,870	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	-
Other Admin Allocation	0	9200-9206-0-0	Participation Fee	-
Bad Debt - Resident	29,932	9200-9207-0-0	Letter of Credit Fee	-
Bad Debt - Resident - Recovery	(620)	9200-9208-0-0	Bond & Draw Fee	-
Bad Debt - Resident Prior Period	-	9200-9209-0-0	Remarketing and Trustee Fee	3,907
Bad Debt - Medicaid Pending Deni	278,186	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	10,000
		9300-9303-0-0	Incentive Management	-
		9300-9303-1-0	Incentive Asset Mgmt Fee	-
		9300-9304-0-0	Tax Credit Fees & Incentive Fee	1,517
		9300-9305-0-0	Organizational Expense	-
		9300-9306-0-0	Developer Fees	-
		9300-9307-0-0	Closing Costs	-
		9700-9702-0-0	Amortization Expense	95,586
		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	-

338,730

111,009

Balance Sheet PG 7 Other, See Attachment

Other Current Assets Detail		Amt	Current Liabilities Detail		Amt
1102-9971-0-0	A/R-Employee Advance	-	2112-0100-0-0	Accrued Asset Management Fee	10,000
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	-
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	26,913
1102-9976-0-0	A/R-Other	4,050	2112-0110-0-0	Accrued Insurance	-
1102-9978-0-0	A/R-TIF/Abatement	-	2112-0115-0-0	Accrued Developer Fee	553,619
1105-0006-0-0	Security Deposit-Equip & Util	492	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	-
			2112-0154-0-0	Unclaimed Property	100
			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	44,386
			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
		4,542	2112-0144-0-0	Payroll Union Dues	0
					635,018
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 PG 8 Other, See Attachment

Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	6,517
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	-
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		6,517

