

		FOR BHF USE			

LL2

Supportive Living Facility

**2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)**

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>1000116</u></p> <p>Facility Name: <u>CAMBRIDGE HOUSE OF SWANSEA</u></p> <hr/> <p>Address: <u>3900 SULLIVAN DRIVE</u> <u>SWANSEA</u> <u>62226</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>ST CLAIR</u></p> <p>Telephone Number: (<u>618</u>) <u>234-8910</u> Fax # <u>618 234-8920</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>03/11/2009</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 checked="" 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 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:</p> <p>Name: <u>Thomas Staszak</u> Telephone Number: <u>(815) 935-1992</u></p> <p>Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</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) (_____)</td> <td>Fax # (_____)</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>David J. Mitchell</u>			(Title) <u>CFO, Gardant Management Solutions</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) (_____)	Fax # (_____)
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																												
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County																																												
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																												
	<input type="checkbox"/> "Sub-S" Corp.	_____																																												
	<input type="checkbox"/> Limited Liability Co.	_____																																												
	<input type="checkbox"/> Trust																																													
	<input type="checkbox"/> Other _____																																													
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 # (_____)																																												

Facility Name: CAMBRIDGE HOUSE OF SWANSEA

Report Period Beginning:

01/01/2016

Ending: 12/31/2016

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	257,538	178,690	2,135	438,363		438,363	1
2	Housekeeping, Laundry and Maintenance	105,976	40,521	52,752	199,249		199,249	2
3	Heat and Other Utilities			140,351	140,351	(28,192)	112,159	3
4	Other (specify): See Page 3 Attachment			19,918	19,918		19,918	4
5	TOTAL General Services	363,514	219,211	215,156	797,881	(28,192)	769,689	5
B. Health Care and Programs								
6	Health Care/ Personal Care	458,184	12,121		470,305		470,305	6
7	Activities and Social Services	18,331	4,645		22,976		22,976	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	476,515	16,766		493,281		493,281	9
C. General Administration								
10	Administrative and Clerical	129,761	23,553	214,616	367,930	(38,203)	329,727	10
11	Marketing Materials, Promotions and Advertising	42,190	10,065	27,728	79,983		79,983	11
12	Employee Benefits and Payroll Taxes			273,811	273,811		273,811	12
13	Insurance-Property, Liability and Malpractice			59,368	59,368		59,368	13
14	Other (specify): See Page 3 Attachment			73,718	73,718	(51,623)	22,095	14
15	TOTAL General Administration	171,951	33,618	649,241	854,810	(89,826)	764,984	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,011,980	269,595	864,397	2,145,972	(118,018)	2,027,954	16
Capital Expenses								
D. Ownership								
17	Depreciation			305,602	305,602		305,602	17
18	Interest			215,027	215,027	(207)	214,820	18
19	Real Estate Taxes			83,116	83,116		83,116	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			6,944	6,944		6,944	21
22	Other (specify): See Page 3 Attachment			1,049,049	1,049,049		1,049,049	22
23	TOTAL Ownership			1,659,738	1,659,738	(207)	1,659,531	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,011,980	269,595	2,524,135	3,805,710	(118,225)	3,687,485	24

Facility Name: CAMBRIDGE HOUSE OF SWANSEA

Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 1	1
2	Licensed Practical Nurses	1	19.89	2
3	Certified Nurse Assistants	16	10.50	3
4	Activity Director & Assistants	Inc line 12	Inc line 1	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	11	9.60	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 1	9
10	Housekeepers	3	9.44	10
11	Laundry			11
12	Managers	4	21.96	12
13	Other Administrative	4	19.24	13
14	Clerical	Inc line 13	Inc line 1	14
15	Marketing	Inc line 12	Inc line 1	15
16	Other			16
17	Total (lines 1 thru 16)	39	\$	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

VI. (B) Management fees paid to unrelated parties

		Amount of Fee		
1	Gardant Management Solutions	\$ 132,596	1	
2			2	
		Total	\$ 132,596	3

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
CAMBRIDGE HOUSE		O'FALLON	
CAMBRIDGE HOUSE OF MARYVILLE		MARYVILLE	

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: CAMBRIDGE HOUSE OF SWANSEA

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VIII. OWNERSHIP COSTS

A. Purchase price of land 425,000 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	103			2009	\$ 7,843,645	\$ 285,223	28	\$ 280,130	\$ (5,093)	\$ 2,222,366	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Leasehold Improvements			236,759	13,969	15	15,784	1,815	131,899	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)				\$ 8,080,404	\$ 299,192		\$ 295,914	\$ (3,278)	\$ 2,354,265	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	\$ 874,877	\$ 6,410	\$ 174,975	168,566	5	\$ 866,041	18
19	Vehicles	53,624			\$		53,624	19
20	TOTAL (lines 18 and 19)	\$ 928,501	\$ 6,410	\$ 174,975	168,566		\$ 919,665	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: CAMBRIDGE HOUSE OF SWANSEA

Report Period Beginning: 01/01/2016

Ending: 2/31/2016

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	Name of Lender	2		3	4	6		7	8	9	
			Related**	YES			NO	Purpose of Loan				
							Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		GERSHMAN MORTGAGE		X	FIRST MORTGAGE	10/11/12	\$ 9,423,200	\$ 8,692,372	11/01/47	.0245	\$ 215,027	1
2						/ /	-		/ /	.0000		2
3						/ /	-		/ /	.0000		3
4						/ /	-		/ /	.0000		
5						/ /	-		/ /	.0000		
		Working Capital										
6						/ /	-		/ /	.0000		4
7		TOTAL Facility Related					\$ 9,423,200	\$ 8,692,372			\$ 215,027	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 9,423,200	\$ 8,692,372			\$ 215,027	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: CAMBRIDGE HOUSE OF SWANSEA

Report Period Beginning: 01/01/2016

Ending:

12/31/2016

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,316,631	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (74,626))	988,044		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,216		6
7	Other Prepaid Expenses	18,215		7
8	Accounts Receivable (owners or related parties)	250		8
9	Other(specify): See Page 7 Attachment	585		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,401,940	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	425,000		13
14	Buildings, at Historical Cost	7,843,645		14
15	Leasehold Improvements, at Historical Cost	236,759		15
16	Equipment, at Historical Cost	928,501		16
17	Accumulated Depreciation (book methods)	(3,273,930)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	225,131		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,385,106	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,787,046	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 29,435	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	28,530		30
31	Accrued Taxes Payable	80,218		31
32	Accrued Interest Payable	17,747		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	283,897		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 439,826	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,533,272		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)	\$ 8,533,272	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,973,098	\$	45
46	TOTAL EQUITY	\$ (186,051)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,787,046	\$	47

*(See instructions.)

Facility Name: CAMBRIDGE HOUSE OF SWANSEA

Report Period Beginning: 01/01/2016

Ending:

12/31/2016

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
I. Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 3,739,176	1
2	Discounts and Allowances	(7,644)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,731,532	3
B. Other Operating Revenue			
4	Special Services	133,053	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	15,786	8
9	Non-Resident Meals	8,780	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 157,619	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	207	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 207	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	1,200	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 1,200	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,890,558	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	797,881	19
20	Health Care/ Personal Care	493,281	20
21	General Administration	854,810	21
B. Capital Expense			
22	Ownership	1,659,738	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)	\$ 3,805,710	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 84,848	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 84,848	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 1,401,249	32
33	Private Pay - Net Inpatient Revenue	2,330,283	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,731,532	37

Expenses PG 3 Other

General Services Other		Health Care & Programs	General Administration Other		Amt	Ownership Other		Amt
5200-5000-0-0	Operating Allocation	-	5160-5060-0-0	Consulting	258	9100-9101-0-0	Interest & Dividend Income	-
5200-5124-0-0	Exterminating	2,200	5160-5063-0-0	Legal	5,566	9100-9102-0-0	Assessment Income	-
5200-5127-0-0	Rubbish Removal	3,614	5160-5064-0-0	Accounting	-	9100-9103-0-0	Assessment Expense	-
5200-5130-0-0	Vehicle Expense	4,416	5160-5066-0-0	Audit	14,810	9200-9201-1-0	Amortization - Loan Fees	5,160
5200-5131-0-0	Transportation Service	-	5160-5067-0-0	Contract Labor-Serv Prov	-	9200-9202-0-0	Financing Fees	-
5300-5140-0-0	Security & Monitoring	9,688	5160-5068-0-0	Contract Labor	1,461	9200-9203-1-0	Mortgage Interest Premium	-
			5180-5079-0-0	Bad Debt - Resident	22,310	9200-9204-0-0	Mortgage Service Fee	-
			5180-5079-1-0	Bad Debt - Resident - Recovery	(133)	9200-9205-0-0	Mortgage Insurance Prem	43,889
			5180-5080-0-0	Bad Debt - Resident Prior Period	-	9200-9206-0-0	Participation Fee	-
			5180-5081-0-0	Bad Debt - Medicaid Pending Denial	29,446	9200-9207-0-0	Letter of Credit Fee	-
			5180-5081-1-0	Bad Debt - Medicaid Pending - Recovery	-	9200-9208-0-0	Bond & Draw Fee	-
			5180-5082-0-0	Bad Debt - Medicaid Denial Prior Period	-	9200-9209-0-0	Remarketing and Trustee Fee	-
			5180-5083-0-0	Bad Debt - Medicaid MCO	-	9200-9210-0-0	Interest Expense-Note	-
			5190-5000-0-0	Other Admin Allocation	-	9200-9211-0-0	Interest Expense-LP	-
						9200-9212-0-0	Debt Write-Off	-
						9300-9301-0-0	Partnership Management Fee	-
						9300-9302-0-0	Asset Management Fee	-
						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	-
						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, Transfe	-
								#####
		19,918						
					73,718			

Balance Sheet

Other Current Assets Detail		Amt	Current Liabilities Detail		Amt
1102-9971-0-0	A/R-Employee Advance	281	2111-0040-0-0	Construction Account Payable	-
1102-9972-0-0	A/R-Gardant Mgmt Solutions	-	2112-0100-0-0	Accrued Asset Management Fee	-
1102-9973-0-0	A/R-Insurance Reimbursemen	-	2112-0101-0-0	Accrued Partnership Mgmt Fee	-
1102-9974-0-0	A/R-Subscription Receivable	-	2112-0102-0-0	Accrued Incentive Mgmt Fee	-
1102-9975-0-0	A/R-CIP	-	2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
1102-9976-0-0	A/R-Other	-	2112-0105-0-0	Accrued Liabilities	254,058
1102-9978-0-0	A/R-TIF/Abatement	-	2112-0110-0-0	Accrued Insurance	-
1105-0006-0-0	Security Deposit-Equip & Util	303	2112-0115-0-0	Accrued Developer Fee	-
1105-0009-0-0	Transfer Account	-	2112-0130-0-0	Accrued MIP	-
1105-0012-0-0	Undeposited Funds	-	2112-0140-0-0	Accrued Vacation	-
			2112-0144-0-0	Payroll Union Dues	-
			2112-0146-0-0	Payroll Benefits	-
			2112-0150-0-0	Security Deposits	-
			2112-0154-0-0	Unclaimed Property	3
			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	29,836
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
		585			283,897

Other Long Term Assets Detail		Amt
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	1,200
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	-
		1,200