

		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>1000134</u></p> <p>Facility Name: <u>HERITAGE WOODS OF CHARLESTON</u></p> <p>Address: <u>480 WEST POLK AVENUE</u> <u>CHARLESTON</u> <u>61920</u> <small>Number City Zip Code</small></p> <p>County: <u>COLES</u></p> <p>Telephone Number: (<u>217</u>) <u>345-4900</u> Fax # <u>217 345-4904</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10/27/2011</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: HERITAGE WOODS OF CHARLESTON

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	180,113	121,653	2,101	303,867		303,867	1
2	Housekeeping, Laundry and Maintenance	76,437	31,242	20,642	128,321		128,321	2
3	Heat and Other Utilities			94,343	94,343	(15,178)	79,165	3
4	Other (specify): See Page 3 Attachment			17,547	17,547		17,547	4
5	TOTAL General Services	256,550	152,895	134,633	544,078	(15,178)	528,900	5
B. Health Care and Programs								
6	Health Care/ Personal Care	290,348	10,264		300,612		300,612	6
7	Activities and Social Services	27,539	5,562		33,101		33,101	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	317,887	15,826		333,713		333,713	9
C. General Administration								
10	Administrative and Clerical	113,364	23,285	232,691	369,340	(17,864)	351,476	10
11	Marketing Materials, Promotions and Advertising	43,054	6,977	31,912	81,943		81,943	11
12	Employee Benefits and Payroll Taxes			153,167	153,167		153,167	12
13	Insurance-Property, Liability and Malpractice			31,200	31,200		31,200	13
14	Other (specify): See Page 3 Attachment			33,062	33,062	(171)	32,891	14
15	TOTAL General Administration	156,418	30,262	482,032	668,712	(18,035)	650,677	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	730,855	198,983	616,665	1,546,503	(33,213)	1,513,290	16
Capital Expenses								
D. Ownership								
17	Depreciation			448,310	448,310		448,310	17
18	Interest			209,847	209,847	(1,487)	208,360	18
19	Real Estate Taxes			70,804	70,804		70,804	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			7,407	7,407		7,407	21
22	Other (specify): See Page 3 Attachment			22,407	22,407		22,407	22
23	TOTAL Ownership			758,775	758,775	(1,487)	757,288	23
24	GRAND TOTAL (Sum of lines 16 and 23)	730,855	198,983	1,375,440	2,305,278	(34,700)	2,270,578	24

Facility Name: HERITAGE WOODS OF CHARLESTON

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	17.93	2
3	Certified Nurse Assistants	11	9.71	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	7	9.35	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 1	9
10	Housekeepers	2	9.00	10
11	Laundry			11
12	Managers	4	18.52	12
13	Other Administrative	3	19.70	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)	28	\$	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	\$ 117,138	1	
2			2	
		Total	\$ 117,138	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
_____		_____	
_____		_____	
_____		_____	

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 CHARLESTON

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VIII. OWNERSHIP COSTS

A. Purchase price of land 35,000 Year land was acquired 2010

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	68			2011	\$ 8,926,302	\$ 324,560	27.5	\$ 324,593	\$ 33	\$ 1,690,461	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Leasehold Improvements				73,127	4,875	15	4,875	0	25,188	6
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17	TOTAL (lines 1 thru 16)				\$ 8,999,429	\$ 329,435		\$ 329,468	\$ 33	\$ 1,715,649	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	\$ 710,962	\$ 118,875	\$ 142,192	23,317	5	\$ 702,805	18
19	Vehicles				\$		-	19
20	TOTAL (lines 18 and 19)	\$ 710,962	\$ 118,875	\$ 142,192	23,317		\$ 702,805	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 CHARLESTON

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	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	LANCASTER POLLARD		X	FIRST MORTGAGE	03/14/14	\$ 4,329,609	\$ 4,198,625	04/01/49	.0497	\$ 209,847	1
2	IHDA		X	SECOND MORTGAGE	08/01/10	865,708	865,708	02/01/37	NONE		2
3					08/01/10	-			NONE		3
4					/ /	-		/ /	.0000		
5						-			.0000		
	Working Capital										
6					/ /	-		/ /	.0000		4
7	TOTAL Facility Related					\$ 5,195,317	\$ 5,064,333			\$ 209,847	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 5,195,317	\$ 5,064,333			\$ 209,847	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: HERITAGE WOODS OF CHARLESTON

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	\$ 576,177	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (7,438))	607,338		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,048		6
7	Other Prepaid Expenses	11,548		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Page 7 Attachment	305		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,214,416	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,000		13
14	Buildings, at Historical Cost	8,926,302		14
15	Leasehold Improvements, at Historical Cost	73,127		15
16	Equipment, at Historical Cost	710,962		16
17	Accumulated Depreciation (book methods)	(2,418,454)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	246,739		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(88,301)		20
21	Restricted Funds	964,561		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attachement</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,449,936	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,664,352	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 34,578	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,119		30
31	Accrued Taxes Payable	71,255		31
32	Accrued Interest Payable	17,389		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	28,342		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 170,683	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,064,333		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)	\$ 5,064,333	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,235,017	\$	45
46	TOTAL EQUITY	\$ 4,429,335	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,664,352	\$	47

*(See instructions.)

Facility Name: HERITAGE WOODS OF CHARLESTON

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	\$ 2,274,535	1
2	Discounts and Allowances	(17,311)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,257,224	3
B. Other Operating Revenue			
4	Special Services	89,798	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	6,560	8
9	Non-Resident Meals	8,852	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 105,210	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	1,487	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,487	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	1,059	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 1,059	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,364,980	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	544,078	19
20	Health Care/ Personal Care	333,713	20
21	General Administration	668,712	21
B. Capital Expense			
22	Ownership	758,775	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)	\$ 2,305,278	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 59,702	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 59,702	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 895,640	32
33	Private Pay - Net Inpatient Revenue	1,361,584	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,257,224	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	13,170	9100-9101-0-0	Interest & Dividend Income	-
5200-5124-0-0	Exterminating	1,120	5160-5063-0-0	Legal	7,340	9100-9102-0-0	Assessment Income	-
5200-5127-0-0	Rubbish Removal	4,554	5160-5064-0-0	Accounting	150	9100-9103-0-0	Assessment Expense	-
5200-5130-0-0	Vehicle Expense	2,475	5160-5066-0-0	Audit	9,510	9200-9201-1-0	Amortization - Loan Fees	-
5200-5131-0-0	Transportation Service	78	5160-5067-0-0	Contract Labor-Serv Prov	-	9200-9202-0-0	Financing Fees	1,000
5300-5140-0-0	Security & Monitoring	9,320	5160-5068-0-0	Contract Labor	2,721	9200-9203-1-0	Mortgage Interest Premium	-
			5180-5079-0-0	Bad Debt - Resident	401	9200-9204-0-0	Mortgage Service Fee	-
			5180-5079-1-0	Bad Debt - Resident - Recovery	-	9200-9205-0-0	Mortgage Insurance Prem	-
			5180-5080-0-0	Bad Debt - Resident Prior Period	-	9200-9206-0-0	Participation Fee	-
			5180-5081-0-0	Bad Debt - Medicaid Pending Denial	(229)	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	3,100
						9300-9305-0-0	Organizational Expense	-
						9300-9306-0-0	Developer Fees	-
						9300-9307-0-0	Closing Costs	-
						9700-9702-0-0	Amortization Expense	18,307
						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	-
		17,547			33,062			22,407

Balance Sheet

Other Current Assets Detail		Amt	Current Liabilities Detail		Amt
1102-9971-0-0	A/R-Employee Advance	-	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	16,259
1102-9978-0-0	A/R-TIF/Abatement	-	2112-0110-0-0	Accrued Insurance	-
1105-0006-0-0	Security Deposit-Equip & Util	305	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	-
			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	12,083
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
		305			28,342

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	1,059
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	-
		1,059