

		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>100099</u></p> <p>Facility Name: <u>HERITAGE WOODS OF DEKALB</u></p> <hr/> <p>Address: <u>2626 N ANNIE GLIDDEN</u> <u>DEKALB</u> <u>60115</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>DEKALB</u></p> <p>Telephone Number: (<u>815</u>) <u>787-6500</u> Fax # <u>815 787-6560</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>12/05/2008</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																																												
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	(Telephone) (_____)	Fax # (_____)																																												

Facility Name DEKALB SLF LP

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

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	27,816	1
2		Double Unit Apartment			2
3		Other			3
4	76	TOTALS	76	27,816	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	16,750	10,441		27,191	5
6	Double Unit					6
7	Other					7
8	TOTALS	16,750	10,441		27,191	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.75%

D. Indicate the number of paid bed-hold days the SLF had during this year

400 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: 2016 Fiscal Year: 2016

* 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: DEKALB SLF LP

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	225,329	147,482	1,843	374,654		374,654	1
2	Housekeeping, Laundry and Maintenance	84,432	41,886	82,976	209,294		209,294	2
3	Heat and Other Utilities			140,745	140,745	(27,775)	112,970	3
4	Other (specify): See Page 3 Attachment			16,512	16,512		16,512	4
5	TOTAL General Services	309,761	189,368	242,076	741,205	(27,775)	713,430	5
B. Health Care and Programs								
6	Health Care/ Personal Care	404,023	9,856		413,879		413,879	6
7	Activities and Social Services	29,908	12,796		42,704		42,704	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	433,931	22,652		456,583		456,583	9
C. General Administration								
10	Administrative and Clerical	154,549	24,948	250,411	429,908	(27,810)	402,098	10
11	Marketing Materials, Promotions and Advertising	59,924	7,139	40,332	107,395		107,395	11
12	Employee Benefits and Payroll Taxes			268,332	268,332		268,332	12
13	Insurance-Property, Liability and Malpractice			37,796	37,796		37,796	13
14	Other (specify): See Page 3 Attachment			69,303	69,303	(28,014)	41,289	14
15	TOTAL General Administration	214,473	32,087	666,174	912,734	(55,824)	856,910	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	958,165	244,107	908,250	2,110,522	(83,599)	2,026,923	16
Capital Expenses								
D. Ownership								
17	Depreciation			328,102	328,102		328,102	17
18	Interest			450,765	450,765	(1,595)	449,170	18
19	Real Estate Taxes			79,901	79,901		79,901	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			7,271	7,271		7,271	21
22	Other (specify): See Page 3 Attachment			254,210	254,210		254,210	22
23	TOTAL Ownership			1,120,249	1,120,249	(1,595)	1,118,654	23
24	GRAND TOTAL (Sum of lines 16 and 23)	958,165	244,107	2,028,499	3,230,771	(85,194)	3,145,577	24

Facility Name: **DEKALB SLF LP**

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	21.28	2
3	Certified Nurse Assistants	13	10.91	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	8	9.48	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 1	9
10	Housekeepers	2	9.19	10
11	Laundry			11
12	Managers	3	21.42	12
13	Other Administrative	4	25.39	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)	31	\$	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	\$ 155,956	1	
2			2	
		Total	\$ 155,956	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: DEKALB SLF LP

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VIII. OWNERSHIP COSTS

A. Purchase price of land 204,014 Year land was acquired 2007

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	76			2008	\$ 8,055,314	\$ 292,920	28	\$ 292,921	\$ 0	\$ 2,502,028	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Leasehold Improvements			443,798	26,184	15	29,587	3,402	273,424	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)				\$ 8,499,112	\$ 319,105		\$ 322,507	\$ 3,402	\$ 2,775,452	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	\$ 646,469	\$ 8,997	\$ 129,294	120,297	5	\$ 626,965	18
19	Vehicles				\$		-	19
20	TOTAL (lines 18 and 19)	\$ 646,469	\$ 8,997	\$ 129,294	120,297		\$ 626,965	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: DEKALB SLF LP

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	AMALGAMATED BANK		X	FIRST MORTGAGE	06/01/07	\$ 8,000,000	\$ 7,275,000	12/01/41	.0610	\$ 450,765
2	DEKALB CO SUPPORTIVE		X	SECOND MORTGAGE	06/06/07	360,000	360,000	12/01/42	NONE	
3					/ /	-		/ /	.0000	
4					/ /	-		/ /	.0000	
5						-			.0000	
	Working Capital									
6					/ /	-		/ /	.0000	
7	TOTAL Facility Related					\$ 8,360,000	\$ 7,635,000			\$ 450,765
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 8,360,000	\$ 7,635,000			\$ 450,765

* 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: DEKALB SLF LP

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	\$ 233,084	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (35,397))	577,533		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,525		6
7	Other Prepaid Expenses	1,830		7
8	Accounts Receivable (owners or related parties)	7,326		8
9	Other(specify): See Page 7 Attachment	670		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 830,968	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	204,014		13
14	Buildings, at Historical Cost	8,055,314		14
15	Leasehold Improvements, at Historical Cost	443,798		15
16	Equipment, at Historical Cost	646,469		16
17	Accumulated Depreciation (book methods)	(3,402,417)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	22,017		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(18,717)		20
21	Restricted Funds	1,198,688		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,149,166	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,980,134	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 19,405	\$	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	80,774		31
32	Accrued Interest Payable	36,981		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	321,608		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 458,768	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,318,567		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)	\$ 7,318,567	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,777,335	\$	45
46	TOTAL EQUITY	\$ 202,798	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,980,134	\$	47

*(See instructions.)

Facility Name: **DEKALB SLF LP**

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	\$ 3,017,820	1
2	Discounts and Allowances	(1,072)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,016,748	3
B. Other Operating Revenue			
4	Special Services	86,358	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	13,762	8
9	Non-Resident Meals	2,139	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 102,259	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	1,595	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,595	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	2,881	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 2,881	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,123,483	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	741,205	19
20	Health Care/ Personal Care	456,583	20
21	General Administration	912,734	21
B. Capital Expense			
22	Ownership	1,120,249	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)	\$ 3,230,771	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (107,288)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (107,288)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 933,863	32
33	Private Pay - Net Inpatient Revenue	2,082,885	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,016,748	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	15,190	9100-9101-0-0	Interest & Dividend Income	-
5200-5124-0-0	Exterminating	1,430	5160-5063-0-0	Legal	8,145	9100-9102-0-0	Assessment Income	-
5200-5127-0-0	Rubbish Removal	2,925	5160-5064-0-0	Accounting	65	9100-9103-0-0	Assessment Expense	-
5200-5130-0-0	Vehicle Expense	2,012	5160-5066-0-0	Audit	12,980	9200-9201-1-0	Amortization - Loan Fees	12,582
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	10,145	5160-5068-0-0	Contract Labor	4,910	9200-9203-1-0	Mortgage Interest Premium	-
			5180-5079-0-0	Bad Debt - Resident	11,619	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	16,394	9200-9207-0-0	Letter of Credit Fee	-
			5180-5081-1-0	Bad Debt - Medicaid Pending - Recovery	-	9200-9208-0-0	Bond & Draw Fee	3,929
			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	19,002
						9300-9303-0-0	Incentive Management	202,059
						9300-9303-1-0	Incentive Asset Mgmt Fee	11,886
						9300-9304-0-0	Tax Credit Fees & Incentive Fee	2,550
						9300-9305-0-0	Organizational Expense	-
						9300-9306-0-0	Developer Fees	-
						9300-9307-0-0	Closing Costs	-
						9700-9702-0-0	Amortization Expense	2,202
						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	-
		16,512			69,303			254,210

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	19,002
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	202,059
1102-9975-0-0	A/R-CIP	-	2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	11,886
1102-9976-0-0	A/R-Other	365	2112-0105-0-0	Accrued Liabilities	39,131
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	44
			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	49,486
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
		670			321,608

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	2,881
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	-
		2,881