

		FOR BHF USE			

LL2

Supportive Living Facility
2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)

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>1000048</u></p> <p>Facility Name: <u>BOWMAN ESTATES</u></p> <hr/> <p>Address: <u>1968 N BOWMAN AVENUE</u> <u>DANVILLE</u> <u>61832</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>VERMILION</u></p> <p>Telephone Number: (<u>217</u>) <u>431-4200</u> Fax # <u>217 431-4252</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10/31/2005</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Thomas Staszak</u> Telephone Number: <u>(815) 935-1992</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <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>01/01/2017</u> to <u>12/31/2017</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;"> <input type="checkbox"/> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>Greg Echols</u> (Title) <u>CFO, Gardant Management Solutions</u> </td> </tr> <tr> <td style="width:20%; vertical-align: top;"> <input type="checkbox"/> 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>	<input type="checkbox"/> Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Greg Echols</u> (Title) <u>CFO, Gardant Management Solutions</u>	<input type="checkbox"/> Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
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<input type="checkbox"/> Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name: BOWMAN ESTATES

Report Period Beginning:

01/01/2017

Ending: 12/31/2017

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	222,232	131,677	1,711	355,620		355,620	1
2	Housekeeping, Laundry and Maintenance	78,296	32,045	37,960	148,301		148,301	2
3	Heat and Other Utilities			105,868	105,868	(19,222)	86,646	3
4	Other (specify): See Page 3 Attachment			35,780	35,780		35,780	4
5	TOTAL General Services	300,528	163,722	181,319	645,569	(19,222)	626,347	5
B. Health Care and Programs								
6	Health Care/ Personal Care	369,381	9,906		379,287		379,287	6
7	Activities and Social Services	27,356	3,662		31,018		31,018	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	396,737	13,568		410,305		410,305	9
C. General Administration								
10	Administrative and Clerical	137,719	31,267	238,871	407,857	(24,604)	383,253	10
11	Marketing Materials, Promotions and Advertising	58,554	6,713	26,862	92,129		92,129	11
12	Employee Benefits and Payroll Taxes			206,734	206,734		206,734	12
13	Insurance-Property, Liability and Malpractice			30,771	30,771		30,771	13
14	Other (specify): See Page 3 Attachment			48,016	48,016	(10,310)	37,706	14
15	TOTAL General Administration	196,273	37,980	551,254	785,507	(34,914)	750,593	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	893,538	215,270	732,572	1,841,380	(54,136)	1,787,244	16
Capital Expenses								
D. Ownership								
17	Depreciation			270,083	270,083		270,083	17
18	Interest			133,759	133,759	(5,267)	128,492	18
19	Real Estate Taxes			55,449	55,449		55,449	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			5,994	5,994		5,994	21
22	Other (specify): See Page 3 Attachment			790,688	790,688		790,688	22
23	TOTAL Ownership			1,255,973	1,255,973	(5,267)	1,250,706	23
24	GRAND TOTAL (Sum of lines 16 and 23)	893,538	215,270	1,988,545	3,097,353	(59,403)	3,037,950	24

Facility Name: BOWMAN ESTATES

Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	20.05	2
3	Certified Nurse Assistants	13	10.03	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	8	9.49	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	2	9.41	10
11	Laundry			11
12	Managers	5	23.16	12
13	Other Administrative	3	23.02	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)	32	\$	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

	Management fees paid to unrelated parties	Amount of Fee	
1	Gardant Management Solutions	\$ 143,499	1
2			2
		Total	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: BOWMAN ESTATES

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land \$ 296,261 Year land was acquired 2004 & 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	76			2005	\$ 6,627,626	\$ 237,787	27.5	\$ 241,005	\$ 3,217	\$ 3,032,954	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Leasehold Improvements				386,694	22,637	15	25,780	3,143	329,402	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)				\$ 7,014,320	\$ 260,424		\$ 266,784	\$ 6,360	\$ 3,362,356	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	\$ 623,951	\$ 9,659	\$ 124,790	115,131	5	\$ 622,633	18
19	Vehicles	22,608			\$	5	22,608	19
20	TOTAL (lines 18 and 19)	\$ 646,559	\$ 9,659	\$ 124,790	115,131		\$ 645,241	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: **BOWMAN ESTATES**

Report Period Beginning: **01/01/2017**

Ending: **12/31/2017**

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	11/20/2012	\$ 4,925,100	\$ 4,491,894	12/1/2047	0.0295	\$ 133,759	1
2											2
3											3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 4,925,100	\$ 4,491,894			\$ 133,759	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 4,925,100	\$ 4,491,894			\$ 133,759	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: BOWMAN ESTATES

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 716,131	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (26,489))	374,429		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,119		6
7	Other Prepaid Expenses	9,526		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Page 7 Attachment	13,828		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,154,032	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	296,261		13
14	Buildings, at Historical Cost	6,627,626		14
15	Leasehold Improvements, at Historical Cost	386,694		15
16	Equipment, at Historical Cost	646,559		16
17	Accumulated Depreciation (book methods)	(4,007,597)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	64,901		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(64,901)		20
21	Restricted Funds	963,474		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,913,016	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,067,049	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 41,163	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	28,182		30
31	Accrued Taxes Payable	57,569		31
32	Accrued Interest Payable	11,043		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	473,984		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 611,942	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,356,109		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)	\$ 4,356,109	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,968,051	\$	45
46	TOTAL EQUITY	\$ 1,098,998	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,067,049	\$	47

*(See instructions.)

Facility Name: BOWMAN ESTATES

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

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	\$ 2,762,468	1
2	Discounts and Allowances	(23,860)	2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 2,738,608	3
B. Other Operating Revenue			
4	Special Services	129,669	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	5,221	8
9	Non-Resident Meals	5,801	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 140,691	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	5,267	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 5,267	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	6,967	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 6,967	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 2,891,533	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	645,569	19
20	Health Care/ Personal Care	410,305	20
21	General Administration	785,507	21
B. Capital Expense			
22	Ownership	1,255,973	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 3,097,353	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (205,820)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (205,820)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 1,397,023	32
33	Private Pay - Net Inpatient Revenue	1,341,585	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,738,608	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	7,052	9100-9101-0-0 Interest & Dividend Income	-
5200-5124-0-0 Exterminating	3,645	5160-5063-0-0 Legal	3,601	9100-9102-0-0 Assessment Income	-
5200-5127-0-0 Rubbish Removal	10,383	5160-5064-0-0 Accounting	155	9100-9103-0-0 Assessment Expense	-
5200-5130-0-0 Vehicle Expense	14,578	5160-5066-0-0 Audit	15,260	9200-9201-1-0 Amortization - Loan Fees	4,552
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	7,174	5160-5068-0-0 Contract Labor	11,637	9200-9203-1-0 Mortgage Interest Premium	-
		5180-5079-0-0 Bad Debt - Resident	1,716	9200-9204-0-0 Mortgage Service Fee	-
		5180-5079-1-0 Bad Debt - Resident - Recovery	-	9200-9205-0-0 Mortgage Insurance Prem	22,671
		5180-5080-0-0 Bad Debt - Resident Prior Period	-	9200-9206-0-0 Participation Fee	-
		5180-5081-0-0 Bad Debt - Medicaid Pending Denial	4,442	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	4,152	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	38,000
				9300-9302-0-0 Asset Management Fee	17,600
				9300-9303-0-0 Incentive Management	706,265
				9300-9303-1-0 Incentive Asset Mgmt Fee	-
				9300-9304-0-0 Tax Credit Fees & Incentive Fee	1,600
				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	-
	35,780		48,016		790,688

Balance Sheet PG 7 Other, See Attachment

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 Reimbursen	-	2112-0101-0-0	Accrued Partnership Mgmt Fee	-
1102-9974-0-0	A/R-Subscription Receivable	-	2112-0102-0-0	Accrued Incentive Mgmt Fee	404,377
1102-9975-0-0	A/R-CIP	-	2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
1102-9976-0-0	A/R-Other	13,775	2112-0105-0-0	Accrued Liabilities	31,036
1102-9978-0-0	A/R-TIF/Abatement	-	2112-0110-0-0	Accrued Insurance	-
1105-0006-0-0	Security Deposit-Equip & Util	53	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	1,040
			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	37,532
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
		13,828			473,984

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

Income Statement		
	Other Revenue	Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	987
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	5,980
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		6,967