

		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.

I. Facility ID Number: 1000063

Facility Name: CAMBRIDGE HOUSE OF MARYVILLE

Address: 6960 STATE ROUTE 162 MARYVILLE 62062
 Number City Zip Code

County: MADISON

Telephone Number: (618) 288-2211 Fax # 618 288-2299

Federal Employer ID Number: _____

Date Current Owners were Certified: 11/29/2006

Type of Ownership:

<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 _____	

In the event there are further questions about this report, please contact:
Name: Thomas Staszak **Telephone Number:** (815) 935-1992
Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2017 to 12/31/2017 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Greg Echols</u>	
	(Title) <u>CFO, Gardant Management Solutions</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____	

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

Facility Name CAMBRIDGE HOUSE OF MARYVILLE

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

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	100	Single Unit Apartment	100	36,500	1
2	3	Double Unit Apartment	3	1,095	2
3		Other			3
4	103	TOTALS	103	37,595	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	28,744	6,075		34,819	5
6	Double Unit					6
7	Other					7
8	TOTALS	28,744	6,075		34,819	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.62%

D. Indicate the number of paid bed-hold days the SLF had during this year
 358 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 10 (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: 2017 Fiscal Year: 2017

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? Yes If yes, did the facility make all of the required payments of interest and principle? Yes
 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: CAMBRIDGE HOUSE OF MARYVILLE

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	236,584	212,456	2,051	451,091		451,091	1
2	Housekeeping, Laundry and Maintenance	114,286	49,034	63,851	227,171		227,171	2
3	Heat and Other Utilities			149,760	149,760	(23,838)	125,922	3
4	Other (specify): See Page 3 Attachment			25,905	25,905		25,905	4
5	TOTAL General Services	350,870	261,490	241,567	853,927	(23,838)	830,089	5
B. Health Care and Programs								
6	Health Care/ Personal Care	460,152	11,379		471,531		471,531	6
7	Activities and Social Services	24,133	4,931		29,064		29,064	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	484,285	16,310		500,595		500,595	9
C. General Administration								
10	Administrative and Clerical	187,271	34,863	367,836	589,970	(28,084)	561,886	10
11	Marketing Materials, Promotions and Advertising	44,975	15,146	55,961	116,082		116,082	11
12	Employee Benefits and Payroll Taxes			258,757	258,757		258,757	12
13	Insurance-Property, Liability and Malpractice			53,077	53,077		53,077	13
14	Other (specify): See Page 3 Attachment			44,159	44,159	(20,474)	23,685	14
15	TOTAL General Administration	232,246	50,009	779,790	1,062,045	(48,558)	1,013,487	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,067,401	327,809	1,021,356	2,416,566	(72,396)	2,344,170	16
Capital Expenses								
D. Ownership								
17	Depreciation			386,305	386,305		386,305	17
18	Interest			398,661	398,661	(19,039)	379,622	18
19	Real Estate Taxes			84,510	84,510		84,510	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			12,597	12,597		12,597	21
22	Other (specify): See Page 3 Attachment			490,973	490,973		490,973	22
23	TOTAL Ownership			1,373,046	1,373,046	(19,039)	1,354,007	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,067,401	327,809	2,394,403	3,789,613	(91,435)	3,698,178	24

Facility Name: CAMBRIDGE HOUSE OF MARYVILLE

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	22.22	2
3	Certified Nurse Assistants	15	11.12	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	10	10.13	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	10.26	10
11	Laundry			11
12	Managers	5	20.23	12
13	Other Administrative	4	23.05	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)	38	\$	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	\$ 213,426	1
2			2
Total		\$ 213,426	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 OF O'FALLON	O'FALLON
CAMBRIDGE HOUSE OF SWANSEA	SWANSEA

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 MARYVILLE

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land \$ 650,127 Year land was acquired 2004

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			2006	\$ 9,629,447	\$ 350,238	27.5	\$ 350,162	\$ (76)	\$ 4,070,286	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Leasehold Improvements				334,649	7,772	15	22,310	14,538	265,477	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)				\$ 9,964,096	\$ 358,010		\$ 372,472	\$ 14,462	\$ 4,335,763	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	\$ 945,390	\$ 28,295	\$ 189,078	160,783	5	\$ 911,405	18
19					\$		-	19
20	TOTAL (lines 18 and 19)	\$ 945,390	\$ 28,295	\$ 189,078	160,783		\$ 911,405	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 MARYVILLE

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

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	
		Related**				Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
A. Directly Facility Related											
Long-Term											
1	IHDA		X	FIRST MORTGAGE	10/1/2006	\$ 6,950,000	\$ 6,104,184	11/1/2041	0.0648	\$ 398,661	1
2											2
3											3
Working Capital											
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 6,950,000	\$ 6,104,184			\$ 398,661	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 6,950,000	\$ 6,104,184			\$ 398,661	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 MARYVILLE

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	\$ 879,649	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (76,944))	623,242		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,508		6
7	Other Prepaid Expenses	16,081		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Page 7 Attachment	117,994		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,690,475	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	650,127		13
14	Buildings, at Historical Cost	9,629,447		14
15	Leasehold Improvements, at Historical Cost	334,649		15
16	Equipment, at Historical Cost	945,390		16
17	Accumulated Depreciation (book methods)	(5,247,168)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	45,895		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(45,895)		20
21	Restricted Funds	1,758,512		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,070,957	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,761,432	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 37,231	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,081		30
31	Accrued Taxes Payable	84,238		31
32	Accrued Interest Payable	32,963		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	608,140		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 796,651	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,053,899		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)	\$ 6,053,899	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 6,850,551	\$	45
46	TOTAL EQUITY	\$ 2,910,881	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,761,432	\$	47

*(See instructions.)

Facility Name: CAMBRIDGE HOUSE OF MARYVILLE

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	\$ 3,502,425	1
2	Discounts and Allowances	(11,032)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,491,393	3
B. Other Operating Revenue			
4	Special Services	134,228	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	15,194	8
9	Non-Resident Meals	7,685	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 157,107	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	19,039	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 19,039	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	6,189	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 6,189	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,673,728	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	853,927	19
20	Health Care/ Personal Care	500,595	20
21	General Administration	1,062,045	21
B. Capital Expense			
22	Ownership	1,373,046	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)	\$ 3,789,613	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (115,885)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (115,885)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 1,472,861	32
33	Private Pay - Net Inpatient Revenue	2,018,532	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,491,393	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	4,257	9100-9101-0-0	Interest & Dividend Income	-
5200-5124-0-0	Exterminating	2,091	5160-5063-0-0	Legal	3,457	9100-9102-0-0	Assessment Income	-
5200-5127-0-0	Rubbish Removal	4,819	5160-5064-0-0	Accounting	185	9100-9103-0-0	Assessment Expense	-
5200-5130-0-0	Vehicle Expense	9,450	5160-5066-0-0	Audit	14,380	9200-9201-1-0	Amortization - Loan Fees	1,776
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	9,544	5160-5068-0-0	Contract Labor	1,406	9200-9203-1-0	Mortgage Interest Premium	-
			5180-5079-0-0	Bad Debt - Resident	25,758	9200-9204-0-0	Mortgage Service Fee	15,380
			5180-5079-1-0	Bad Debt - Resident - Recovery	-	9200-9205-0-0	Mortgage Insurance Prem	30,546
			5180-5080-0-0	Bad Debt - Resident Prior Period	-	9200-9206-0-0	Participation Fee	-
			5180-5081-0-0	Bad Debt - Medicaid Pending Denial	(5,283)	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	25,000
						9300-9302-0-0	Asset Management Fee	5,004
						9300-9303-0-0	Incentive Management	391,167
						9300-9303-1-0	Incentive Asset Mgmt Fee	-
						9300-9304-0-0	Tax Credit Fees & Incentive Fee	2,100
						9300-9305-0-0	Organizational Expense	-
						9300-9306-0-0	Developer Fees	-
						9300-9307-0-0	Closing Costs	-
						9700-9702-0-0	Amortization Expense	-
						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	20,000
						9900-9907-0-0	Abandonment Loss	-
						9900-9908-0-0	Grant Income	-
						9900-9909-0-0	Misc: Title, Recording, Transfe	-
		25,905			44,159			490,973

Balance Sheet PG 7 Other

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	5,004
1102-9973-0-0	A/R-Insurance Reimbursemen	-	2112-0101-0-0	Accrued Partnership Mgmt Fee	25,000
1102-9974-0-0	A/R-Subscription Receivable	-	2112-0102-0-0	Accrued Incentive Mgmt Fee	391,167
1102-9975-0-0	A/R-CIP	-	2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
1102-9976-0-0	A/R-Other	117,670	2112-0105-0-0	Accrued Liabilities	160,590
1102-9978-0-0	A/R-TIF/Abatement	-	2112-0110-0-0	Accrued Insurance	-
1105-0006-0-0	Security Deposit-Equip & Util	324	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	6,664
			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	19,715
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
		117,994			608,140

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 PG 8 Other

Income Statement		
Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	395
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	5,794
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		6,189