

		FOR BHF USE			

LL2

Supportive Living Facility

**2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)**

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 AVE</u> <u>DANVILLE</u> <u>61832</u> <small>Number City Zip Code</small></p> <p>County: <u>VERMILION</u></p> <p>Telephone Number: <u>(217) 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><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>	<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>01/01/2018</u> to <u>12/31/2018</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>Greg Echols</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) <u>()</u> _____</td> <td>Fax # () _____</td> </tr> </table>	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 # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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	(Firm Name & Address) _____																																													
	(Telephone) <u>()</u> _____	Fax # () _____																																												
<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>																																														
<p>MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001</p> <p align="right">Phone # (217) 782-1630</p>																																														

Facility Name: BOWMAN ESTATES

Report Period Beginning:

01/01/2018

Ending: 12/31/2018

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	235,993	140,237	1,657	377,887		377,887	1
2	Housekeeping, Laundry and Maintenance	81,870	34,266	50,358	166,494		166,494	2
3	Heat and Other Utilities			109,048	109,048	(17,580)	91,468	3
4	Other (specify):			31,252	31,252		31,252	4
5	TOTAL General Services	317,863	174,503	192,315	684,681	(17,580)	667,101	5
B. Health Care and Programs								
6	Health Care/ Personal Care	401,944	11,622		413,566		413,566	6
7	Activities and Social Services	34,256	5,043		39,299		39,299	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	436,200	16,665		452,865		452,865	9
C. General Administration								
10	Administrative and Clerical	147,353	33,717	235,342	416,412	(17,872)	398,540	10
11	Marketing Materials, Promotions and Advertising	54,001	5,759	33,387	93,147		93,147	11
12	Employee Benefits and Payroll Taxes			190,261	190,261		190,261	12
13	Insurance-Property, Liability and Malpractice			26,274	26,274		26,274	13
14	Other (specify):			67,119	67,119	(18,289)	48,829	14
15	TOTAL General Administration	201,354	39,476	552,383	793,213	(36,161)	757,052	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	955,417	230,644	744,698	1,930,759	(53,741)	1,877,017	16
Capital Expenses								
D. Ownership								
17	Depreciation			265,179	265,179		265,179	17
18	Interest			131,007	131,007	(21,349)	109,658	18
19	Real Estate Taxes			63,010	63,010		63,010	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			6,061	6,061		6,061	21
22	Other (specify):			613,252	613,252		613,252	22
23	TOTAL Ownership			1,078,509	1,078,509	(21,349)	1,057,159	23
24	GRAND TOTAL (Sum of lines 16 and 23)	955,417	230,644	1,823,206	3,009,267	(75,090)	2,934,177	24

Facility Name: BOWMAN ESTATES

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

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	21.21	2
3	Certified Nurse Assistants	13	11.10	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	10.37	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	2	10.10	10
11	Laundry			11
12	Managers	5	23.30	12
13	Other Administrative	3	23.39	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

		Amount of Fee	
1	Gardant Management Solutions	\$ 126,556	1
2			2
		Total	\$ 126,556 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:

01/01/2018

Ending:

12/31/2018

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	\$ 241,318	27.5	\$ 241,005	\$ (314)	\$ 3,274,272	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Leasehold Improvements				399,194	22,993	15	26,613	3,620	352,394	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)				\$ 7,026,820	\$ 264,311		\$ 267,618	\$ 3,307	\$ 3,626,667	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	\$ 869	\$ 124,790	123,921	5	\$ 623,502	18
19	Vehicles	22,608		4,522	4,522	5	22,608	19
20	TOTAL (lines 18 and 19)	\$ 646,559	\$ 869	\$ 129,312	128,443		\$ 646,110	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: **01/01/2018**

Ending: **12/31/2018**

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		
	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	11/20/12	\$ 4,925,100	\$ 4,397,328	12/1/47	0.0295	\$ 131,007
2										
3										
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 4,925,100	\$ 4,397,328			\$ 131,007
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 4,925,100	\$ 4,397,328			\$ 131,007

* 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: 01/01/2018

Ending:

12/31/2018

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 690,795	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (44,778))	272,479		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,525		6
7	Other Prepaid Expenses	14,945		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Page 7 Attachment	11,225		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,038,969	\$	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	399,194		15
16	Equipment, at Historical Cost	646,559		16
17	Accumulated Depreciation (book methods)	(4,272,777)		17
18	Deferred Charges	53		18
19	Organization & Pre-Operating Costs	64,901		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(64,901)		20
21	Restricted Funds	871,042		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,567,958	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,606,927	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 51,826	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,417		30
31	Accrued Taxes Payable	64,828		31
32	Accrued Interest Payable	10,810		32
33	Deferred Compensation	408		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	429,541		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 589,830	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,266,095		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)	\$ 4,266,095	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,855,925	\$	45
46	TOTAL EQUITY	\$ 751,002	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,606,927	\$	47

*(See instructions.)

Facility Name: BOWMAN ESTATES

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

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	\$ 2,672,990	1
2	Discounts and Allowances	(10,441)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,662,549	3
B. Other Operating Revenue			
4	Special Services	102,529	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	3,276	8
9	Non-Resident Meals	966	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 106,771	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	21,349	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 21,349	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	8,331	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 8,331	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,799,000	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	684,681	19
20	Health Care/ Personal Care	452,865	20
21	General Administration	793,213	21
B. Capital Expense			
22	Ownership	1,078,509	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)	\$ 3,009,267	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (210,267)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (210,267)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 1,384,905	32
33	Private Pay - Net Inpatient Revenue	1,277,644	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,662,549	37

Operating Expenses PG 3 Other			
A. General Services		D. Ownership	
Other (specify):		Other (specify):	Amt
5200-5000-0-0	Operating Allocation	9100-9101-0-0	Interest & Dividend Income
			-
5200-5124-0-0	Exterminating	9100-9102-0-0	Assessment Income
	4,050		-
5200-5127-0-0	Rubbish Removal	9100-9103-0-0	Assessment Expense
	8,195		-
5200-5130-0-0	Vehicle Expense	9200-9201-1-0	Amortization - Loan Fees
	13,843		4,552
5200-5131-0-0	Transportation Service	9200-9202-0-0	Financing Fees
	-		-
5300-5140-0-0	Security & Monitoring	9200-9203-1-0	Mortgage Interest Premium
	5,164		-
	PG3-4.3		
			31,252
C. General Administration			
Other (specify):	Amt		
5160-5060-0-0	Consulting	9200-9204-0-0	Mortgage Service Fee
	310		-
5160-5063-0-0	Legal	9200-9205-0-0	Mortgage Insurance Prem
	2,708		22,205
5160-5064-0-0	Accounting	9200-9206-0-0	Participation Fee
	115		-
5160-5066-0-0	Audit	9200-9207-0-0	Letter of Credit Fee
	15,700		-
5160-5067-0-0	Contract Labor-Serv Prov	9200-9208-0-0	Bond & Draw Fee
	-		-
5160-5068-0-0	Contract Labor	9200-9209-0-0	Remarketing and Trustee Fee
	29,996		-
5180-5079-0-0	Bad Debt - Resident	9200-9210-0-0	Interest Expense-Note
	18,289		-
5180-5079-1-0	Bad Debt - Resident - Recovery	9200-9211-0-0	Interest Expense-LP
	-		-
5180-5080-0-0	Bad Debt - Resident Prior Period	9200-9212-0-0	Debt Write-Off
	-		-
5180-5081-0-0	Bad Debt - Medicaid Pending Denial	9300-9301-0-0	Partnership Management Fee
	-		38,000
5180-5081-1-0	Bad Debt - Medicaid Pending - Recovery	9300-9302-0-0	Asset Management Fee
	-		17,600
5180-5082-0-0	Bad Debt - Medicaid Denial Prior Period	9300-9303-0-0	Incentive Management
	-		530,895
5180-5083-0-0	Bad Debt - Medicaid MCO	9300-9303-1-0	Incentive Asset Mgmt Fee
	-		-
5190-5000-0-0	Other Admin Allocation	9300-9304-0-0	Tax Credit Fees & Incentive Fee
	-		-
	PG3-14.3	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, Transfer
			-
			PG3-22.3
			613,252
B. Health Care and Programs			
Other (specify):	PG3-8.3		

Operating Expenses - Reclassifications and Adjustments PG 3		
A. General Services		
Heat and Other Utilities		
3300-3303-0-0	Cable	17,580
	PG3-3.5	17,580
C. General Administration		
Administrative and Clerical		
3300-3301-0-0	Beauty Salon & Manicure	3,276
3300-3304-0-0	Internet Access	-
3300-3321-0-0	Telephone- Connection	13,449
3300-3323-0-0	Telephone- Usage	197
5190-5090-0-0	Contributions	950
	PG3-10.5	17,872
C. General Administration		
Other (specify):		
5180-5079-0-0	Bad Debt - Resident	18,289
5180-5079-1-0	Bad Debt - Resident - Recovery	-
5180-5080-0-0	Bad Debt - Resident Prior Period	-
5180-5081-0-0	Bad Debt - Medicaid Pending Denial	-
5180-5081-1-0	Bad Debt - Medicaid Pending - Recovery	-
5180-5082-0-0	Bad Debt - Medicaid Denial Prior Period	-
5180-5083-0-0	Bad Debt - Medicaid MCO	-
	PG3-14.5	18,289
D. Ownership		
Interest		
3300-3380-0-0	Interest Income	19,442
3300-3385-0-0	Interest Income - Reserves	1,907
	PG3-18.5	21,349
D. Ownership		
Other (specify):		
1302-1007-0-0	A/A - Goodwill	-
9200-9209-0-0	Remarketing and Trustee Fee	-
	PG3-22.5	-

Balance Sheet PG 7 Other

Balance Sheet

Other Current Assets Detail		Amt
1102-9971-0-0	A/R-Employee Advance	-
1102-9972-0-0	A/R-Gardant Mgmt Solutions	-
1102-9973-0-0	A/R-Insurance Reimbursement	-
1102-9974-0-0	A/R-Subscription Receivable	-
1102-9975-0-0	A/R-CIP	-
1102-9976-0-0	A/R-Other	11,225
1102-9978-0-0	A/R-TIF/Abatement	-
1105-0009-0-0	Transfer Account	-
1105-0012-0-0	Undeposited Funds	-
PG7-9.1		11,225

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	-
PG7-23.1		-

Current Liabilities Detail		Amt
2111-0040-0-0	Construction Account Payable	-
2112-0100-0-0	Accrued Asset Management Fee	8,800
2112-0101-0-0	Accrued Partnership Mgmt Fee	19,000
2112-0102-0-0	Accrued Incentive Mgmt Fee	349,143
2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
2112-0105-0-0	Accrued Liabilities	26,984
2112-0110-0-0	Accrued Insurance	-
2112-0115-0-0	Accrued Developer Fee	-
2112-0130-0-0	Accrued MIP	-
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	997
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	24,617
2112-0159-1-0	Medicaid Prepayments	-
2112-0159-2-0	Prepaid Medicaid Clearing	-
2112-0159-3-0	Prepaid Rent	-
PG7-35.1		429,541

Income Statement PG 8 Other

Income Statement

Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	1,290 NSF, call pendant
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	7,041
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-

PG8-15.1	8,331
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