

		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><b>I. Facility ID Number:</b> 1000149</p> <p><b>Facility Name:</b> <u>GATEWAY AT RIVER CITY</u></p> <p><b>Address:</b> <u>518 W ROMEO B GARRET</u> <u>PEORIA</u> <u>61605</u>  Number City Zip Code</p> <p><b>County:</b> <u>PEORIA</u></p> <p><b>Telephone Number:</b> ( <u>309</u> ) <u>673-3115</u> <b>Fax #</b> <u>309 673-3117</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>10/27/2016</u></p> <p><b>Type of Ownership:</b></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>Charitable Corp.</td> <td>Individual</td> <td>State</td> </tr> <tr> <td>Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td>County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td>Corporation</td> <td>Other _____</td> </tr> <tr> <td></td> <td>"Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td>Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td>Trust</td> <td></td> </tr> <tr> <td></td> <td>Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Thomas Staszak</u> <b>Telephone Number:</b> <u>(815) 935-1992</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	Charitable Corp.	Individual	State	Trust	<input checked="" type="checkbox"/> Partnership	County	IRS Exemption Code _____	Corporation	Other _____		"Sub-S" Corp.			Limited Liability Co.			Trust			Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></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 border="1" style="width: 100%;"> <tr> <td rowspan="2" style="width: 15%; text-align: center; vertical-align: middle;">Officer or Administrator of Provider</td> <td style="width: 85%;">(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Greg Echols</u></td> </tr> <tr> <td></td> <td>(Title) <u>CFO, Gardant Management Solutions</u></td> </tr> <tr> <td rowspan="4" style="width: 15%; text-align: center; vertical-align: middle;">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td>(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>	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) ( ) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
Charitable Corp.	Individual	State																																	
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	(Type or Print Name) <u>Greg Echols</u>																																		
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Paid Preparer	(Signed) _____ (Date) _____																																		
	(Print Name and Title) _____																																		
	(Firm Name & Address) _____																																		
	(Telephone) ( ) _____ Fax # ( ) _____																																		

Facility Name GATEWAY AT RIVER CITY

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	5	Double Unit Apartment	5	1,825	2
3		Other			3
4	105	TOTALS	105	38,325	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	21,181	1,035		22,216	5
6	Double Unit					6
7	Other					7
8	TOTALS	21,181	1,035		22,216	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 57.97%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 469 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 7 (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)

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**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?** 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: GATEWAY AT RIVER CITY

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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	168,779	128,197	2,007	298,983		298,983	1
2	Housekeeping, Laundry and Maintenance	77,460	18,912	14,234	110,606		110,606	2
3	Heat and Other Utilities			96,775	96,775	(7,236)	89,539	3
4	Other (specify): See Page 3 Attachment			15,168	15,168		15,168	4
5	<b>TOTAL General Services</b>	<b>246,239</b>	<b>147,109</b>	<b>128,184</b>	<b>521,532</b>	<b>(7,236)</b>	<b>514,296</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	356,129	11,289		367,418		367,418	6
7	Activities and Social Services	33,694	4,624		38,318		38,318	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>389,823</b>	<b>15,913</b>		<b>405,736</b>		<b>405,736</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	186,704	24,406	194,663	405,773	(2,430)	403,343	10
11	Marketing Materials, Promotions and Advertising	65,356	6,748	44,619	116,723		116,723	11
12	Employee Benefits and Payroll Taxes			199,167	199,167		199,167	12
13	Insurance-Property, Liability and Malpractice			51,803	51,803		51,803	13
14	Other (specify): See Page 3 Attachment			109,136	109,136	(64,599)	44,537	14
15	<b>TOTAL General Administration</b>	<b>252,060</b>	<b>31,154</b>	<b>599,388</b>	<b>882,602</b>	<b>(67,029)</b>	<b>815,573</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>888,122</b>	<b>194,176</b>	<b>727,572</b>	<b>1,809,870</b>	<b>(74,265)</b>	<b>1,735,605</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			690,399	690,399		690,399	17
18	Interest			287,421	287,421	(1,809)	285,612	18
19	Real Estate Taxes			115,019	115,019		115,019	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			8,123	8,123		8,123	21
22	Other (specify): See Page 3 Attachment			85,501	85,501		85,501	22
23	<b>TOTAL Ownership</b>			<b>1,186,463</b>	<b>1,186,463</b>	<b>(1,809)</b>	<b>1,184,654</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>888,122</b>	<b>194,176</b>	<b>1,914,036</b>	<b>2,996,334</b>	<b>(76,074)</b>	<b>2,920,260</b>	<b>24</b>

Facility Name: GATEWAY AT RIVER CITY

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	27.03	2
3	Certified Nurse Assistants	10	11.90	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	6	10.62	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	2	9.43	10
11	Laundry			11
12	Managers	4	23.86	12
13	Other Administrative	4	20.80	13
14	Clerical	Inc line 13	Inc line 13	14
15	Marketing	Inc line 12	Inc line 12	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>27</b>	<b>\$</b>	<b>17</b>

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
<b>Total</b>				<b>\$</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Management fees paid to unrelated parties	Amount of Fee	
1	Gardant Management Solutions	\$ 106,812	1
2			2
<b>Total</b>		<b>\$ 106,812</b>	<b>3</b>

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: GATEWAY AT RIVER CITY

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land \$ 1,793,354 Year land was acquired 2015

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	105			2016	\$ 10,406,017	\$ 260,150	40	\$ 260,150	\$ 0	\$ 318,639	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	Leasehold Improvements				1,186,018	59,302	20	59,301	(1)	72,624	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)				\$ 11,592,035	\$ 319,452		\$ 319,451	\$ (1)	\$ 391,263	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	\$ 3,715,746	\$ 370,947	\$	(370,947)	10	\$ 454,142	18
19					\$		-	19
20	TOTAL (lines 18 and 19)	\$ 3,715,746	\$ 370,947	\$	(370,947)		\$ 454,142	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: GATEWAY AT RIVER CITY

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	<b>TOTAL</b>			\$			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	Name of Lender	2		3	4	6		7	8	9						
			Related**				Purpose of Loan	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
			YES	NO									Original	Balance			
		<b>A. Directly Facility Related</b>															
		<b>Long-Term</b>															
1		P/R MORTGAGE & INVEST		X	FIRST MORTGAGE	5/1/2015	\$ 9,000,000	\$ 8,889,293	12/1/1956	0.0328	\$ 287,421	1					
2												2					
3												3					
		<b>Working Capital</b>															
4						/ /			/ /			4					
5						/ /			/ /			5					
6						/ /			/ /			6					
7		<b>TOTAL Facility Related</b>					\$ 9,000,000	\$ 8,889,293			\$ 287,421	7					
		<b>B. Non-Facility Related</b>															
8						/ /			/ /			8					
9						/ /			/ /			9					
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 9,000,000	\$ 8,889,293			\$ 287,421	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: GATEWAY AT RIVER CITY

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 437,378	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (64,599) )	622,659		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,393		6
7	Other Prepaid Expenses	3,256		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Page 7 Attachment	2,222		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,081,907	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,793,354		13
14	Buildings, at Historical Cost	10,406,017		14
15	Leasehold Improvements, at Historical Cost	1,186,018		15
16	Equipment, at Historical Cost	3,715,746		16
17	Accumulated Depreciation (book methods)	(845,405)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	141,004		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(14,100)		20
21	Restricted Funds	850,585		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 17,233,219	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 18,315,126	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 31,358	\$	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	80,259		31
32	Accrued Interest Payable	24,297		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	See Page 7 Attachment	1,034,870		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 1,170,785	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,612,703		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 8,612,703	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 9,783,488	\$	45
46	<b>TOTAL EQUITY</b>	\$ 8,531,638	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 18,315,126	\$	47

\*(See instructions.)

Facility Name: GATEWAY AT RIVER CITY

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	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 2,113,471	1
2	Discounts and Allowances	(10,584)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 2,102,887</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services	80,065	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	153	8
9	Non-Resident Meals	3,472	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 83,690</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	1,809	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 1,809</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	See Page 8 Attachment	4,975	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 4,975</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 2,193,361</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	521,532	19
20	Health Care/ Personal Care	405,736	20
21	General Administration	882,602	21
<b>B. Capital Expense</b>			
22	Ownership	1,186,463	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 2,996,334</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (802,973)</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ (802,973)</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 1,386,264	32
33	Private Pay - Net Inpatient Revenue	716,623	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 2,102,887</b>	<b>37</b>



**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	120	9100-9101-0-0	Interest & Dividend Income	-
5200-5124-0-0	Exterminating	2,910	5160-5063-0-0	Legal	17,177	9100-9102-0-0	Assessment Income	-
5200-5127-0-0	Rubbish Removal	6,193	5160-5064-0-0	Accounting	-	9100-9103-0-0	Assessment Expense	-
5200-5130-0-0	Vehicle Expense	2,842	5160-5066-0-0	Audit	19,680	9200-9201-1-0	Amortization - Loan Fees	9,576
5200-5131-0-0	Transportation Service	44	5160-5067-0-0	Contract Labor-Serv Prov	-	9200-9202-0-0	Financing Fees	-
5300-5140-0-0	Security & Monitoring	3,179	5160-5068-0-0	Contract Labor	7,560	9200-9203-1-0	Mortgage Interest Premium	-
			5180-5079-0-0	Bad Debt - Resident	55,323	9200-9204-0-0	Mortgage Service Fee	-
			5180-5079-1-0	Bad Debt - Resident - Recovery	-	9200-9205-0-0	Mortgage Insurance Prem	42,275
			5180-5080-0-0	Bad Debt - Resident Prior Period	-	9200-9206-0-0	Participation Fee	-
			5180-5081-0-0	Bad Debt - Medicaid Pending Denial	9,275	9200-9207-0-0	Letter of Credit Fee	4,100
			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	15,450
						9300-9303-0-0	Incentive Management	-
						9300-9303-1-0	Incentive Asset Mgmt Fee	-
						9300-9304-0-0	Tax Credit Fees & Incentive Fee	-
						9300-9305-0-0	Organizational Expense	-
						9300-9306-0-0	Developer Fees	-
						9300-9307-0-0	Closing Costs	-
						9700-9702-0-0	Amortization Expense	14,100
						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	-
		15,168			109,136			85,501

**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	15,450
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	22,757
1102-9978-0-0	A/R-TIF/Abatement	-	2112-0110-0-0	Accrued Insurance	-
1105-0006-0-0	Security Deposit-Equip & Util	2,222	2112-0115-0-0	Accrued Developer Fee	992,640
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	405
			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	3,618
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
		2,222			#####

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	4,975
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	-
		4,975