

		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>1000085</u></p> <p>Facility Name: <u>HERITAGE WOODS OF ROCKFORD</u></p> <p>Address: <u>202 N SHOWPLACE DR</u> <u>ROCKFORD</u> <u>61107</u> <small>Number City Zip Code</small></p> <p>County: <u>WINNABAGO</u></p> <p>Telephone Number: (<u>815</u>) <u>332-5777</u> Fax # <u>815 332-3407</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>9/3/2008</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: Name: <u>Thomas Staszak</u> Telephone Number: <u>(815) 935-1992</u> 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>01/01/2017</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%;">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 # (<u> </u>) _____</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) (<u> </u>) _____	Fax # (<u> </u>) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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	(Telephone) (<u> </u>) _____	Fax # (<u> </u>) _____																																												

Facility Name HERITAGE WOODS OF ROCKFORD

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	99	Single Unit Apartment	99	36,135	1
2		Double Unit Apartment			2
3		Other			3
4	99	TOTALS	99	36,135	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	29,819	6,230		36,049	5
6	Double Unit					6
7	Other					7
8	TOTALS	29,819	6,230		36,049	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.76%

D. Indicate the number of paid bed-hold days the SLF had during this year
 430 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)

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: HERITAGE WOODS OF ROCKFORD

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	250,701	204,161	2,650	457,512		457,512	1
2	Housekeeping, Laundry and Maintenance	112,228	47,984	73,652	233,864		233,864	2
3	Heat and Other Utilities			133,590	133,590	(29,972)	103,618	3
4	Other (specify): See Page 3 Attachment			17,739	17,739		17,739	4
5	TOTAL General Services	362,929	252,145	227,631	842,705	(29,972)	812,733	5
B. Health Care and Programs								
6	Health Care/ Personal Care	472,638	12,847		485,485		485,485	
7	Activities and Social Services	36,298	8,422		44,720		44,720	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	508,936	21,269		530,205		530,205	9
C. General Administration								
10	Administrative and Clerical	186,100	30,792	259,213	476,105	(37,235)	438,870	10
11	Marketing Materials, Promotions and Advertising	71,125	16,662	31,884	119,671		119,671	11
12	Employee Benefits and Payroll Taxes			314,617	314,617		314,617	12
13	Insurance-Property, Liability and Malpractice			39,671	39,671		39,671	13
14	Other (specify): See Page 3 Attachment			461,276	461,276	(4,656)	456,620	14
15	TOTAL General Administration	257,225	47,454	1,106,661	1,411,340	(41,891)	1,369,449	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,129,090	320,868	1,334,292	2,784,250	(71,863)	2,712,387	16
Capital Expenses								
D. Ownership								
17	Depreciation			445,260	445,260		445,260	17
18	Interest			374,758	374,758	(10,214)	364,544	18
19	Real Estate Taxes			100,081	100,081		100,081	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			12,885	12,885		12,885	21
22	Other (specify): See Page 3 Attachment			794,476	794,476		794,476	22
23	TOTAL Ownership			1,727,460	1,727,460	(10,214)	1,717,246	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,129,090	320,868	3,061,753	4,511,711	(82,077)	4,429,634	24

Facility Name: HERITAGE WOODS OF ROCKFORD

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	25.25	2
3	Certified Nurse Assistants	14	11.17	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	10.34	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	10.94	10
11	Laundry			11
12	Managers	5	27.05	12
13	Other Administrative	4	24.33	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)	37	\$	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	
###					4	
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	\$ 160,384	1
2			2
		Total	\$ 160,384 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: HERITAGE WOODS OF ROCKFORD

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land \$ 416,192 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	99			2007	\$ 9,933,775	\$ 366,974	27.5	\$ 361,228	\$ (5,746)	\$ 3,649,613	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Leasehold Improvements			682,761	40,648	15.00	45,517	4,870	477,990	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)				\$ 10,616,536	\$ 407,622		\$ 406,746	\$ (876)	\$ 4,127,603	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	\$ 786,252	\$ 37,637	\$ 157,250	119,613	5	\$ 731,297	18
19					\$		-	19
20	TOTAL (lines 18 and 19)	\$ 786,252	\$ 37,637	\$ 157,250	119,613		\$ 731,297	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: **HERITAGE WOODS OF ROCKFORD**

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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		IHDA		X	FIRST MORTGAGE	8/24/2006	\$ 7,850,000	\$ 6,505,599	3/1/2038	0.0540	\$ 355,615	1
2		IHDA		X	Second Mortgage	8/24/2006	1,914,283	1,914,283	3/1/2038	0.0100	19,143	2
3												3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 9,764,283	\$ 8,419,882			\$ 374,758	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 9,764,283	\$ 8,419,882			\$ 374,758	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: HERITAGE WOODS OF ROCKFORD

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	\$ 854,790	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (24,321))	521,093		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,879		6
7	Other Prepaid Expenses	2,686		7
8	Accounts Receivable (owners or related parties)	3,552		8
9	Other(specify): See Page 7 Attachment	12,006		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,412,006	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	416,192		13
14	Buildings, at Historical Cost	9,933,775		14
15	Leasehold Improvements, at Historical Cost	682,761		15
16	Equipment, at Historical Cost	786,252		16
17	Accumulated Depreciation (book methods)	(4,858,900)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	22,733		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(22,733)		20
21	Restricted Funds	2,091,235		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Page 7 Attachment	3,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,054,315	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,466,321	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 113,799	\$	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	104,354		31
32	Accrued Interest Payable	30,870		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	1,665,825		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,914,849	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,193,134		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)	\$ 8,193,134	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,107,983	\$	45
46	TOTAL EQUITY	\$ 358,338	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,466,321	\$	47

*(See instructions.)

Facility Name: HERITAGE WOODS OF ROCKFORD

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	\$ 3,827,060	1
2	Discounts and Allowances	(1,320)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,825,740	3
B. Other Operating Revenue			
4	Special Services	152,826	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	19,840	8
9	Non-Resident Meals	7,967	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 180,633	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	10,214	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 10,214	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	8,441	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 8,441	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,025,028	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	842,705	19
20	Health Care/ Personal Care	530,205	20
21	General Administration	1,411,340	21
B. Capital Expense			
22	Ownership	1,727,460	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)	\$ 4,511,711	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (486,683)	29
30	Income Taxes		30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (486,683)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 1,594,340	32
33	Private Pay - Net Inpatient Revenue	2,231,400	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,825,740	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	307,169	9100-9101-0-0 Interest & Dividend Income	-
5200-5124-0-0 Exterminating	2,886	5160-5063-0-0 Legal	6,840	9100-9102-0-0 Assessment Income	-
5200-5127-0-0 Rubbish Removal	5,347	5160-5064-0-0 Accounting	-	9100-9103-0-0 Assessment Expense	-
5200-5130-0-0 Vehicle Expense	3,639	5160-5066-0-0 Audit	17,220	9200-9201-1-0 Amortization - Loan Fees	11,484
5200-5131-0-0 Transportation Service	-	5160-5067-0-0 Contract Labor-Serv Prov	105,282	9200-9202-0-0 Financing Fees	-
5300-5140-0-0 Security & Monitoring	5,868	5160-5068-0-0 Contract Labor	20,110	9200-9203-1-0 Mortgage Interest Premium	-
		5180-5079-0-0 Bad Debt - Resident	(7,433)	9200-9204-0-0 Mortgage Service Fee	-
		5180-5079-1-0 Bad Debt - Resident - Recovery	(4,011)	9200-9205-0-0 Mortgage Insurance Prem	32,923
		5180-5080-0-0 Bad Debt - Resident Prior Period	-	9200-9206-0-0 Participation Fee	-
		5180-5081-0-0 Bad Debt - Medicaid Pending Denial	16,099	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	-
				9300-9302-0-0 Asset Management Fee	35,822
				9300-9303-0-0 Incentive Management	589,833
				9300-9303-1-0 Incentive Asset Mgmt Fee	117,967
				9300-9304-0-0 Tax Credit Fees & Incentive Fee	1,975
				9300-9305-0-0 Organizational Expense	-
				9300-9306-0-0 Developer Fees	-
				9300-9307-0-0 Closing Costs	-
				9700-9702-0-0 Amortization Expense	1,738
				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	2,735
				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	-
	17,739		461,276		794,476

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	35,822
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	1,380,772
1102-9975-0-0	A/R-CIP	-	2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	188,386
1102-9976-0-0	A/R-Other	11,677	2112-0105-0-0	Accrued Liabilities	30,767
1102-9978-0-0	A/R-TIF/Abatement	-	2112-0110-0-0	Accrued Insurance	-
1105-0006-0-0	Security Deposit-Equip & Util	329	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	0
			2112-0144-0-0	Payroll Union Dues	0
			2112-0146-0-0	Payroll Benefits	-
			2112-0150-0-0	Security Deposits	-
			2112-0154-0-0	Unclaimed Property	329
			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	29,749
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
		12,006			1,665,825
Other Long Term Assets Detail					
1201-0020-0-0	CIP	-			
1201-0021-0-0	CIP- Land Option Addition	3,000			
1201-0022-0-0	CIP- Other Addition	-			
		3,000.00			

Income Statement PG 8 Other

Income Statement			
	Other Revenue	Amt	
3300-3388-0-0	Contract Service-Serv Prov	-	
3300-3390-0-0	Other	2,107	
3300-3391-0-0	Property Tax Adjustments	-	
3300-3392-0-0	Property Lease Income	-	
3300-3393-0-0	Insurance Adjustments	6,335	
3300-3395-0-0	Developer Fee Income	-	
3300-3396-0-0	Home Office Rent Income	-	
		8,441	0
			0