

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2016  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2016)**

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> <u>1000085</u></p> <p><b>Facility Name:</b> <u>HERITAGE WOODS OF ROCKFORD</u></p> <p><b>Address:</b> <u>202 N SHOWPLACE DR</u> <u>ROCKFORD</u> <u>61107</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>WINNABAGO</u></p> <p><b>Telephone Number:</b> ( <u>815</u> ) <u>332-5777</u> Fax # <u>815 332-3407</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>09/03/2008</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><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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>Thomas Staszak</u> <b>Telephone Number:</b> <u>(815) 935-1992</u></p> <p><b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<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><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>01/01/2016</u> to <u>12/31/2016</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%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>David J. Mitchell</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO, Gardant Management Solutions</u></td> <td></td> </tr> <tr> <td><b>Paid Preparer</b></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 &amp; Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) ( _____ )</td> <td>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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>David J. Mitchell</u>			(Title) <u>CFO, Gardant Management Solutions</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) ( _____ )	Fax # ( _____ )
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Facility Name HERITAGE WOODS OF ROCKFORDReport Period Beginning: 01/01/2016 Ending: 12/31/2016**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	36,234	1
2		Double Unit Apartment			2
3		Other			3
4	99	TOTALS	99	36,234	4

**B. Census-For the entire report period.**

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		Total
5	Single Unit	29,076	6,967		36,043	5
6	Double Unit					6
7	Other					7
8	TOTALS	29,076	6,967		36,043	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.47%

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

645 Also, indicate the number of unpaid bed-hold days the SLF had during this year.            (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  NOTax Year: 2016 Fiscal Year: 2016

\* 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:

01/01/2016

Ending: 12/31/2016

## 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	241,582	182,279	1,845	425,706		425,706	1
2	Housekeeping, Laundry and Maintenance	109,811	32,622	84,637	227,070		227,070	2
3	Heat and Other Utilities			140,604	140,604	(30,973)	109,631	3
4	Other (specify): See Page 3 Attachment			16,766	16,766		16,766	4
5	<b>TOTAL General Services</b>	<b>351,393</b>	<b>214,901</b>	<b>243,852</b>	<b>810,146</b>	<b>(30,973)</b>	<b>779,173</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	442,855	12,463		455,318		455,318	6
7	Activities and Social Services	35,371	6,746		42,117		42,117	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>478,226</b>	<b>19,209</b>		<b>497,435</b>		<b>497,435</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	183,385	28,517	257,757	469,659	(39,615)	430,044	10
11	Marketing Materials, Promotions and Advertising	71,132	15,703	33,225	120,060		120,060	11
12	Employee Benefits and Payroll Taxes			299,640	299,640		299,640	12
13	Insurance-Property, Liability and Malpractice			51,135	51,135		51,135	13
14	Other (specify): See Page 3 Attachment			427,230	427,230	299	427,529	14
15	<b>TOTAL General Administration</b>	<b>254,517</b>	<b>44,220</b>	<b>1,068,987</b>	<b>1,367,724</b>	<b>(39,316)</b>	<b>1,328,408</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,084,136</b>	<b>278,330</b>	<b>1,312,839</b>	<b>2,675,305</b>	<b>(70,289)</b>	<b>2,605,016</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			451,288	451,288		451,288	17
18	Interest			383,850	383,850	(4,724)	379,126	18
19	Real Estate Taxes			102,789	102,789		102,789	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			12,368	12,368		12,368	21
22	Other (specify): See Page 3 Attachment			190,435	190,435		190,435	22
23	<b>TOTAL Ownership</b>			<b>1,140,730</b>	<b>1,140,730</b>	<b>(4,724)</b>	<b>1,136,006</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,084,136</b>	<b>278,330</b>	<b>2,453,569</b>	<b>3,816,035</b>	<b>(75,013)</b>	<b>3,741,022</b>	<b>24</b>

Facility Name: HERITAGE WOODS OF ROCKFORD

Report Period Beginning: 01/01/2016 Ending: 12/31/2016

**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 1	1
2	Licensed Practical Nurses	1	24.59	2
3	Certified Nurse Assistants	14	10.45	3
4	Activity Director & Assistants	Inc line 12	Inc line 1	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	10	10.28	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 1	9
10	Housekeepers	3	10.61	10
11	Laundry			11
12	Managers	4	22.46	12
13	Other Administrative	4	21.58	13
14	Clerical	Inc line 13	Inc line 1	14
15	Marketing	Inc line 12	Inc line 1	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>36</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**

		Amount of Fee		
1	Gardant Management Solutions	\$ 156,558	1	
2			2	
		<b>Total</b>	<b>\$ 156,558</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: HERITAGE WOODS OF ROCKFORD

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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)	\$ 3,282,639	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Leasehold Improvements			682,761	40,886	15	45,517	4,631	437,342	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	\$ 407,860		\$ 406,746	\$ (1,115)	\$ 3,719,981	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	\$ 785,041	\$ 43,429	\$ 157,008	113,579	5	\$ 693,659	18
19	Vehicles				\$		-	19
20	TOTAL (lines 18 and 19)	\$ 785,041	\$ 43,429	\$ 157,008	113,579		\$ 693,659	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: **01/01/2016**

Ending: **2/31/2016**

**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

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				
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1	IHDA		X	FIRST MORTGAGE	08/24/06	\$ 7,850,000	\$ 6,678,169	03/01/38	.0540	\$ 383,850	
2	IHDA		X	SECOND MORTGAGE	08/24/06	1,914,283	1,914,283	03/01/38	.0100		
3					/ /	-		/ /			
4					/ /	-		/ /			
5						-					
	<b>Working Capital</b>										
6					/ /	-		/ /			
7	<b>TOTAL Facility Related</b>					\$ 9,764,283	\$ 8,592,452			\$ 383,850	
	<b>B. Non-Facility Related</b>										
8					/ /			/ /			
9					/ /			/ /			
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 9,764,283	\$ 8,592,452			\$ 383,850	

\* 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: 01/01/2016

Ending:

12/31/2016

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 406,727	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (26,662) )	1,024,136		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,069		6
7	Other Prepaid Expenses	2,835		7
8	Accounts Receivable (owners or related parties)	10,919		8
9	Other(specify): See Page 7 Attachment	12,080		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,477,766	\$	10
	<b>B. Long-Term Assets</b>			
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	785,041		16
17	Accumulated Depreciation (book methods)	(4,413,641)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	22,733		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(20,995)		20
21	Restricted Funds	1,891,407		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>	\$ 9,297,272	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 10,775,038	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 93,091	\$	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	103,689		31
32	Accrued Interest Payable	31,647		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	See Page 7 Attachment	1,314,026		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 1,542,453	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,354,220		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>	\$ 8,354,220	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 9,896,673	\$	45
46	<b>TOTAL EQUITY</b>	\$ 878,365	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 10,775,038	\$	47

\*(See instructions.)

Facility Name: HERITAGE WOODS OF ROCKFORD

Report Period Beginning: 01/01/2016

Ending:

12/31/2016

## 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	\$ 3,754,087	1
2	Discounts and Allowances	(4,104)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 3,749,983</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services	150,648	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	21,065	8
9	Non-Resident Meals	9,707	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 181,420</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	4,724	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 4,724</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	See Page 8 Attachment	2,620	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 2,620</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 3,938,747</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	810,146	19
20	Health Care/ Personal Care	497,435	20
21	General Administration	1,367,724	21
<b>B. Capital Expense</b>			
22	Ownership	1,140,730	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>\$ 3,816,035</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 122,712</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>\$ 122,712</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 1,646,781	32
33	Private Pay - Net Inpatient Revenue	2,103,202	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>\$ 3,749,983</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	226,919	9100-9101-0-0 Interest & Dividend Income	-
5200-5124-0-0 Exterminating	4,303	5160-5063-0-0 Legal	11,516	9100-9102-0-0 Assessment Income	-
5200-5127-0-0 Rubbish Removal	5,116	5160-5064-0-0 Accounting	-	9100-9103-0-0 Assessment Expense	-
5200-5130-0-0 Vehicle Expense	1,875	5160-5066-0-0 Audit	17,700	9200-9201-1-0 Amortization - Loan Fees	11,484
5200-5131-0-0 Transportation Service	(43)	5160-5067-0-0 Contract Labor-Serv Prov	150,210	9200-9202-0-0 Financing Fees	-
5300-5140-0-0 Security & Monitoring	5,514	5160-5068-0-0 Contract Labor	21,185	9200-9203-1-0 Mortgage Interest Premium	-
		5180-5079-0-0 Bad Debt - Resident	10,478	9200-9204-0-0 Mortgage Service Fee	-
		5180-5079-1-0 Bad Debt - Resident - Recovery	(360)	9200-9205-0-0 Mortgage Insurance Prem	33,765
		5180-5080-0-0 Bad Debt - Resident Prior Period	-	9200-9206-0-0 Participation Fee	-
		5180-5081-0-0 Bad Debt - Medicaid Pending Denial	(10,418)	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	34,778
				9300-9303-0-0 Incentive Management	87,302
				9300-9303-1-0 Incentive Asset Mgmt Fee	17,460
				9300-9304-0-0 Tax Credit Fees & Incentive Fee	3,378
				9300-9305-0-0 Organizational Expense	-
				9300-9306-0-0 Developer Fees	-
				9300-9307-0-0 Closing Costs	-
				9700-9702-0-0 Amortization Expense	2,268
				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	-
	16,766		427,230		190,435

Balance Sheet

Other Current Assets Detail			Current Liabilities Detail		
		Amt			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	34,778
1102-9973-0-0	A/R-Insurance Reimbursemen	11,288	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	120,435
1102-9976-0-0	A/R-Other	463	2112-0105-0-0	Accrued Liabilities	33,680
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	-
			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	10,884
			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	73,232
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
		12,080			#####
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

Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	2,620
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	-
		2,620