

		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>1000129</u></p> <p>Facility Name: <u>HERITAGE WOODS OF BELVIDERE</u></p> <p>Address: <u>4730 SQUAW PRAIRIE</u> <u>BELVIDERE</u> <u>61008</u> <small>Number City Zip Code</small></p> <p>County: <u>BOONE</u></p> <p>Telephone Number: (<u>815</u>) <u>544-9495</u> Fax # <u>815 544-9525</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>4/25/2011</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 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 checked="" 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 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 checked="" 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 BELVIDERE

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	120	Single Unit Apartment	120	43,800	1
2		Double Unit Apartment			2
3		Other			3
4	120	TOTALS	120	43,800	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	31,883	11,437		43,320	5
6	Double Unit					6
7	Other					7
8	TOTALS	31,883	11,437		43,320	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.90%

D. Indicate the number of paid bed-hold days the SLF had during this year
 1,010 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 28 (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 BELVIDERE

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	279,302	241,874	2,737	523,913		523,913	1
2	Housekeeping, Laundry and Maintenance	139,439	45,450	51,355	236,244		236,244	2
3	Heat and Other Utilities			137,567	137,567	(37,047)	100,520	3
4	Other (specify): See Page 3 Attachment			21,642	21,642		21,642	4
5	TOTAL General Services	418,741	287,324	213,301	919,366	(37,047)	882,319	5
B. Health Care and Programs								
6	Health Care/ Personal Care	572,625	15,253		587,878		587,878	6
7	Activities and Social Services	34,435	12,186		46,621		46,621	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	607,060	27,439		634,499		634,499	9
C. General Administration								
10	Administrative and Clerical	236,052	34,986	362,854	633,892	(52,013)	581,879	10
11	Marketing Materials, Promotions and Advertising	56,036	16,383	54,237	126,656		126,656	11
12	Employee Benefits and Payroll Taxes			322,961	322,961		322,961	12
13	Insurance-Property, Liability and Malpractice			47,730	47,730		47,730	13
14	Other (specify): See Page 3 Attachment			75,754	75,754	(28,338)	47,416	14
15	TOTAL General Administration	292,088	51,369	863,536	1,206,993	(80,351)	1,126,642	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,317,889	366,132	1,076,837	2,760,858	(117,398)	2,643,460	16
Capital Expenses								
D. Ownership								
17	Depreciation			643,455	643,455		643,455	17
18	Interest			455,593	455,593	(1,377)	454,216	18
19	Real Estate Taxes			99,032	99,032		99,032	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			10,393	10,393		10,393	21
22	Other (specify): See Page 3 Attachment			76,179	76,179		76,179	22
23	TOTAL Ownership			1,284,652	1,284,652	(1,377)	1,283,275	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,317,889	366,132	2,361,489	4,045,510	(118,775)	3,926,735	24

Facility Name: HERITAGE WOODS OF BELVIDERE

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	2	23.34	2
3	Certified Nurse Assistants	18	10.77	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	12	9.93	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	4	9.63	10
11	Laundry			11
12	Managers	5	22.58	12
13	Other Administrative	6	21.01	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)	47	\$	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1				\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Management fees paid to unrelated parties	Amount of Fee	
1	Gardant Management Solutions	\$ 251,652	1
2			2
Total		\$ 251,652	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 BELVIDERE

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land \$ 99 Year land was acquired 2011

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	120			2011	\$ 16,617,308	\$ 604,205	27.5	\$ 604,266	\$ 61	\$ 4,054,879	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Leasehold Improvements				553,830	36,940	15	36,922	(18)	240,083	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)				\$ 17,171,138	\$ 641,145		\$ 641,188	\$ 43	\$ 4,294,962	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	\$ 879,686	\$ 2,310	\$ 175,937	173,627	5	\$ 876,029	18
19					\$		-	19
20	TOTAL (lines 18 and 19)	\$ 879,686	\$ 2,310	\$ 175,937	173,627		\$ 876,029	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 BELVIDERE**

Report Period Beginning: **01/01/2017**

Ending: **12/31/2017**

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs of Lease	Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				\$			7

8. Is movable equipment rental included in building rental? YES NO

YES NO

9. Rental amount for movable equipment \$ _____

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	2	3	4	6	7	8	9		
	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	9/1/2015	\$ 10,875,000	\$ 10,583,306	9/1/2051	0.0425	\$ 452,499
2	IHDA		X	Second Mortgage	12/30/2009	5,997,823	5,954,040	10/1/2051	none	
3										
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 16,872,823	\$ 16,537,346			\$ 452,499
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 16,872,823	\$ 16,537,346			\$ 452,499

* 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 BELVIDERE

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	\$ 1,988,100	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (75,591))	664,322		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,716		6
7	Other Prepaid Expenses	21,782		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Page 7 Attachment	350		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,749,270	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	99		13
14	Buildings, at Historical Cost	16,617,308		14
15	Leasehold Improvements, at Historical Cost	553,830		15
16	Equipment, at Historical Cost	879,686		16
17	Accumulated Depreciation (book methods)	(5,170,990)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	273,524		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(86,009)		20
21	Restricted Funds	1,963,732		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,031,180	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,780,450	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 53,845	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,640		30
31	Accrued Taxes Payable	105,340		31
32	Accrued Interest Payable	37,483		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	59,133		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 297,440	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	16,375,526		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)	\$ 16,375,526	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 16,672,966	\$	45
46	TOTAL EQUITY	\$ 1,107,484	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 17,780,450	\$	47

*(See instructions.)

Facility Name: HERITAGE WOODS OF BELVIDERE

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	\$ 4,874,011	1
2	Discounts and Allowances	(347)	2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 4,873,664	3
B. Other Operating Revenue			
4	Special Services	182,188	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	27,532	8
9	Non-Resident Meals	11,883	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 221,603	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	1,377	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 1,377	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	6,926	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 6,926	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 5,103,570	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	919,366	19
20	Health Care/ Personal Care	634,499	20
21	General Administration	1,206,993	21
B. Capital Expense			
22	Ownership	1,284,652	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 4,045,510	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 1,058,060	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 1,058,060	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 1,927,740	32
33	Private Pay - Net Inpatient Revenue	2,945,924	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 4,873,664	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	9,493	9100-9101-0-0	Interest & Dividend Income	-
5200-5124-0-0	Exterminating	3,115	5160-5063-0-0	Legal	3,830	9100-9102-0-0	Assessment Income	-
5200-5127-0-0	Rubbish Removal	6,381	5160-5064-0-0	Accounting	68	9100-9103-0-0	Assessment Expense	-
5200-5130-0-0	Vehicle Expense	3,107	5160-5066-0-0	Audit	13,092	9200-9201-1-0	Amortization - Loan Fees	2,413
5200-5131-0-0	Transportation Service	-	5160-5067-0-0	Contract Labor-Serv Prov	-	9200-9202-0-0	Financing Fees	-
5300-5140-0-0	Security & Monitoring	9,039	5160-5068-0-0	Contract Labor	20,933	9200-9203-1-0	Mortgage Interest Premium	-
			5180-5079-0-0	Bad Debt - Resident	29,942	9200-9204-0-0	Mortgage Service Fee	-
			5180-5079-1-0	Bad Debt - Resident - Recovery	(907)	9200-9205-0-0	Mortgage Insurance Prem	58,556
			5180-5080-0-0	Bad Debt - Resident Prior Period	-	9200-9206-0-0	Participation Fee	-
			5180-5081-0-0	Bad Debt - Medicaid Pending Denial	(697)	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	-
						9300-9303-0-0	Incentive Management	-
						9300-9303-1-0	Incentive Asset Mgmt Fee	-
						9300-9304-0-0	Tax Credit Fees & Incentive Fee	2,400
						9300-9305-0-0	Organizational Expense	-
						9300-9306-0-0	Developer Fees	-
						9300-9307-0-0	Closing Costs	-
						9700-9702-0-0	Amortization Expense	12,810
						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	-
		21,642						
					75,754			
								76,179

Balance Sheet PG 7 Other

Balance Sheet PG 7 Other, See Attachment

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	-
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	-
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	36,034
1102-9978-0-0	A/R-TIF/Abatement	-	2112-0110-0-0	Accrued Insurance	-
1105-0006-0-0	Security Deposit-Equip & Util	350	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	3,746
			2112-0155-0-0	Reservation Deposit	-
			2112-0156-0-0	Buy Down Credit	-
			2112-0157-0-0	Unapplied Last Month Rent	-
			2112-0158-0-0	Deferred Gain on Sale	-
			2112-0159-0-0	Unearned Revenue	19,353
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
		350			59,133

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, See Attachment

Income Statement		
	Other Revenue	Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	2,326
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	4,600
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		6,926