

		FOR BHF USE			

LL2

**Supportive Living Facility**

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

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p><b>I. Facility ID Number:</b> <u>1000077</u></p> <p><b>Facility Name:</b> <u>PRAIRIE WINDS OF URBANA</u></p> <hr/> <p><b>Address:</b> <u>1905 S PRAIRIE WINDS</u> <u>URBANA</u> <u>61801</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>CHAMPAIGN</u></p> <p><b>Telephone Number:</b> ( <u>217</u> ) <u>344-6400</u> Fax # <u>217 344-6444</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>9/19/2007</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>01/01/2018</u> to <u>12/31/2018</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></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><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) ( <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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>Greg Echols</u>			(Title) <u>CFO, Gardant Management Solutions</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) ( <u>   </u> ) _____	Fax # ( <u>   </u> ) _____
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Facility Name PRAIRIE WINDS OF URBANA

Report Period Beginning: 01/01/2018 Ending: 12/31/2018

**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	94	Single Unit Apartment	94	34,310	1
2		Double Unit Apartment			2
3		Other			3
4	94	TOTALS	94	34,310	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	24,650	7,953		32,603	5
6	Double Unit					6
7	Other					7
8	TOTALS	24,650	7,953		32,603	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 95.02%

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

562 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 26 (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: 2018 Fiscal Year: 2018

\* 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? N/A  
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: PRAIRIE WINDS OF URBANA

Report Period Beginning:

01/01/2018

Ending: 12/31/2018

## IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
<b>A. General Services</b>								
1	Dietary and Food Purchase	290,865	201,834	2,076	494,775		494,775	1
2	Housekeeping, Laundry and Maintenance	96,921	32,509	72,163	201,593		201,593	2
3	Heat and Other Utilities			134,898	134,898	(24,914)	109,984	3
4	Other (specify):			25,666	25,666		25,666	4
5	<b>TOTAL General Services</b>	387,786	234,343	234,803	856,932	(24,914)	832,018	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	419,626	13,890		433,516		433,516	6
7	Activities and Social Services	40,281	8,799		49,080		49,080	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	459,907	22,689		482,596		482,596	9
<b>C. General Administration</b>								
10	Administrative and Clerical	139,833	29,250	250,067	419,150	(26,329)	392,821	10
11	Marketing Materials, Promotions and Advertising	72,823	7,417	29,170	109,410		109,410	11
12	Employee Benefits and Payroll Taxes			189,280	189,280		189,280	12
13	Insurance-Property, Liability and Malpractice			32,201	32,201		32,201	13
14	Other (specify):			113,356	113,356	(58,084)	55,272	14
15	<b>TOTAL General Administration</b>	212,656	36,667	614,074	863,397	(84,413)	778,984	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	1,060,349	293,699	848,878	2,202,926	(109,327)	2,093,598	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			203,490	203,490		203,490	17
18	Interest			237,461	237,461	(15,666)	221,796	18
19	Real Estate Taxes			134,508	134,508		134,508	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			6,474	6,474		6,474	21
22	Other (specify):			40,623	40,623		40,623	22
23	<b>TOTAL Ownership</b>			622,556	622,556	(15,666)	606,891	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	1,060,349	293,699	1,471,434	2,825,482	(124,993)	2,700,489	24

Facility Name: PRAIRIE WINDS OF URBANA

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

V. STAFFING AND SALARY COSTS (Please report each line separately.)

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	Inc line 12	\$ Inc line 12	1
2	Licensed Practical Nurses	1	21.44	2
3	Certified Nurse Assistants	13	11.60	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	11.31	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	9.80	10
11	Laundry			11
12	Managers	6	22.74	12
13	Other Administrative	3	22.36	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>35</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	\$ 179,670	1	
2			2	
		<b>Total</b>	<b>\$ 179,670</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: PRAIRIE WINDS OF URBANA

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

VIII. OWNERSHIP COSTS

A. Purchase price of land 566,500 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	94			2007	\$ 5,720,129	\$ 143,027	40	\$ 143,003	\$ (23)	\$ 1,583,403	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Leasehold Improvements			718,277	35,914	20	35,914	0	413,151	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)				\$ 6,438,406	\$ 178,940		\$ 178,917	\$ (23)	\$ 1,996,554	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	\$ 1,247,313	\$ 18,115	\$ 249,463	231,347	5	\$ 1,143,371	18
19	Vehicles	45,039	6,434	6,434	(0)	7	19,839	19
20	TOTAL (lines 18 and 19)	\$ 1,292,353	\$ 24,549	\$ 255,897	231,347		\$ 1,163,210	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: PRAIRIE WINDS OF URBANA

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: \_\_\_\_\_

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

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	<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	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	OPPENHEIMER		X	FIRST MORTGAGE	3/1/12	\$ 7,899,276	\$ 7,020,979	1/1/47	0.0335	\$ 237,461
2										
3										
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$ 7,899,276	\$ 7,020,979			\$ 237,461
	<b>B. Non-Facility Related</b>									
8					/ /			/ /		
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 7,899,276	\$ 7,020,979			\$ 237,461

\* 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: PRAIRIE WINDS OF URBANA

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,030,979	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (84,117) )	706,814		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,867		6
7	Other Prepaid Expenses	8,106		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <a href="#">See Page 7 Attachment</a>	525		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,788,292	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	566,500		13
14	Buildings, at Historical Cost	5,720,129		14
15	Leasehold Improvements, at Historical Cost	718,277		15
16	Equipment, at Historical Cost	1,292,353		16
17	Accumulated Depreciation (book methods)	(3,159,764)		17
18	Deferred Charges	275		18
19	Organization & Pre-Operating Costs	11,579		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(11,579)		20
21	Restricted Funds	278,698		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>	\$ 5,416,468	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 7,204,760	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 53,697	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,856		30
31	Accrued Taxes Payable	95,996		31
32	Accrued Interest Payable	19,600		32
33	Deferred Compensation	1,646		33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<a href="#">See Page 7 Attachment</a>	62,985		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 291,781	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,902,773		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>	\$ 6,902,773	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 7,194,554	\$	45
46	<b>TOTAL EQUITY</b>	\$ 10,206	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 7,204,760	\$	47

\*(See instructions.)

Facility Name: PRAIRIE WINDS OF URBANA

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

## XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 3,556,239	1
2	Discounts and Allowances	(3,501)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 3,552,738</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services	112,016	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	7,345	8
9	Non-Resident Meals	3,241	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 122,602</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	15,666	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 15,666</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	See Page 8 Attachment	442,105	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 442,105</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 4,133,111</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	856,932	19
20	Health Care/ Personal Care	482,596	20
21	General Administration	863,397	21
<b>B. Capital Expense</b>			
22	Ownership	622,556	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>\$ 2,825,482</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 1,307,629</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>\$ 1,307,629</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 1,406,605	32
33	Private Pay - Net Inpatient Revenue	2,146,133	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>\$ 3,552,738</b>	<b>37</b>



**Balance Sheet PG 7 Other**

Balance Sheet

Other Current Assets Detail		Amt
1102-9971-0-0	A/R-Employee Advance	197
1102-9972-0-0	A/R-Gardant Mgmt Solutions	243
1102-9973-0-0	A/R-Insurance Reimbursement	-
1102-9974-0-0	A/R-Subscription Receivable	-
1102-9975-0-0	A/R-CIP	-
1102-9976-0-0	A/R-Other	85
1102-9978-0-0	A/R-TIF/Abatement	-
1105-0009-0-0	Transfer Account	-
1105-0012-0-0	Undeposited Funds	-
<b>PG7-9.1</b>		<b>525</b>

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	-
<b>PG7-23.1</b>		<b>-</b>

Current Liabilities Detail		Amt
2111-0040-0-0	Construction Account Payable	-
2112-0100-0-0	Accrued Asset Management Fee	-
2112-0101-0-0	Accrued Partnership Mgmt Fee	-
2112-0102-0-0	Accrued Incentive Mgmt Fee	-
2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
2112-0105-0-0	Accrued Liabilities	25,537
2112-0110-0-0	Accrued Insurance	-
2112-0115-0-0	Accrued Developer Fee	-
2112-0130-0-0	Accrued MIP	-
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	4,650
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	32,797
2112-0159-1-0	Medicaid Prepayments	-
2112-0159-2-0	Prepaid Medicaid Clearing	-
2112-0159-3-0	Prepaid Rent	-
<b>PG7-35.1</b>		<b>62,985</b>
		125969.4

**Income Statement PG 8 Other**

Income Statement

	Other Revenue	Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other (NSF fees, Late fees, Call pendants)	2,403
3300-3391-0-0	Property Tax Adjustments	434,249
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	5,453
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-

<b>PG8-15.1</b>	<b>442,105</b>
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