

		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>1000041</u></p> <p><b>Facility Name:</b> <u>CHURCHVIEW SUPPORTVE LVG CTR</u></p> <hr/> <p><b>Address:</b> <u>2626 WEST 63RD ST</u> <u>CHICAGO</u> <u>60629</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>( 773 ) 471-4444</u> Fax # <u>773 471-3935</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>3/24/2005</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> Fax # <u>( )</u></td> <td></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 CHURCHVIEW SUPPORTVE LVG CTR

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	86	Single Unit Apartment	86	31,390	1
2		Double Unit Apartment			2
3		Other			3
4	86	TOTALS	86	31,390	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		
5	Single Unit	26,319	363		26,682	5
6	Double Unit					6
7	Other					7
8	TOTALS	26,319	363		26,682	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 85.00%

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

1,241 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 35 (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: 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? \_\_\_\_\_

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: CHURCHVIEW SUPPORTVE LVG CTR

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	259,192	150,948	2,319	412,459		412,459	1
2	Housekeeping, Laundry and Maintenance	92,489	154,236	99,736	346,461		346,461	2
3	Heat and Other Utilities			190,495	190,495	(10,291)	180,204	3
4	Other (specify):			81,238	81,238		81,238	4
5	<b>TOTAL General Services</b>	<b>351,681</b>	<b>305,184</b>	<b>373,788</b>	<b>1,030,653</b>	<b>(10,291)</b>	<b>1,020,362</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	411,939	12,311		424,250		424,250	6
7	Activities and Social Services	38,560	12,156		50,716		50,716	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>450,499</b>	<b>24,467</b>		<b>474,966</b>		<b>474,966</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	224,116	30,373	264,362	518,851	(9,394)	509,457	10
11	Marketing Materials, Promotions and Advertising	63,778	6,509	35,111	105,398		105,398	11
12	Employee Benefits and Payroll Taxes			315,350	315,350		315,350	12
13	Insurance-Property, Liability and Malpractice			37,707	37,707		37,707	13
14	Other (specify):			110,167	110,167	(28,312)	81,855	14
15	<b>TOTAL General Administration</b>	<b>287,894</b>	<b>36,882</b>	<b>762,697</b>	<b>1,087,473</b>	<b>(37,706)</b>	<b>1,049,767</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,090,074</b>	<b>366,533</b>	<b>1,136,485</b>	<b>2,593,092</b>	<b>(47,997)</b>	<b>2,545,095</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			500,470	500,470		500,470	17
18	Interest			79,431	79,431	(33,207)	46,224	18
19	Real Estate Taxes			79,614	79,614		79,614	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			13,986	13,986		13,986	21
22	Other (specify):			168,135	168,135	(10,010)	158,124	22
23	<b>TOTAL Ownership</b>			<b>841,636</b>	<b>841,636</b>	<b>(43,217)</b>	<b>798,418</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,090,074</b>	<b>366,533</b>	<b>1,978,121</b>	<b>3,434,728</b>	<b>(91,215)</b>	<b>3,343,513</b>	<b>24</b>

Facility Name: CHURCHVIEW SUPPORTVE LVG CTR

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	24.95	2
3	Certified Nurse Assistants	11	12.96	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	9	13.16	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	1	12.17	10
11	Laundry			11
12	Managers	4	18.40	12
13	Other Administrative	5	24.00	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>31</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	\$ 140,937	1	
2			2	
		<b>Total</b>	<b>\$ 140,937</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: CHURCHVIEW SUPPORTVE LVG CTR

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

VIII. OWNERSHIP COSTS

A. Purchase price of land 1,302,647 Year land was acquired 1998-2000

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	86			2004	\$ 12,319,858	\$ 447,995	27.5	\$ 447,995	\$ (0)	\$ 6,429,893	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	Leasehold Improvements				300,149	20,010	15	20,010	(0)	278,554	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)				\$ 12,620,007	\$ 468,005		\$ 468,005	\$ (0)	\$ 6,708,447	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	\$ 507,477	\$ 32,465	\$ 101,495	69,031	5	\$ 411,201	18
19					\$ -		-	19
20	TOTAL (lines 18 and 19)		\$ 507,477	\$ 32,465	\$ 101,495	69,031	\$ 411,201	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: CHURCHVIEW SUPPORTVE LVG CTR

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

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	HARRIS TRUST & SAVING		X	FIRST MORTGAGE	3/1/03	\$ 7,555,000	\$ 5,410,000	9/1/33	variable	\$ 79,431
2	CITY OF CHICAGO DEPT C		X	Second Mortgage	3/1/03	4,000,000	4,000,000	3/1/35	none	
3										
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$ 11,555,000	\$ 9,410,000			\$ 79,431
	<b>B. Non-Facility Related</b>									
8					/ /			/ /		
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 11,555,000	\$ 9,410,000			\$ 79,431

\* 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: CHURCHVIEW SUPPORTVE LVG CTR

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	\$ 394,462	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (75,167) )	568,022		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,557		6
7	Other Prepaid Expenses	6,726		7
8	Accounts Receivable (owners or related parties)	11,820		8
9	Other(specify): <a href="#">See Page 7 Attachment</a>	3,484		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 997,071	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,302,647		13
14	Buildings, at Historical Cost	12,319,858		14
15	Leasehold Improvements, at Historical Cost	300,149		15
16	Equipment, at Historical Cost	507,477		16
17	Accumulated Depreciation (book methods)	(7,119,648)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	205,780		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(205,780)		20
21	Restricted Funds	893,138		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>	\$ 8,203,621	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 9,200,692	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 126,815	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	80,498		31
32	Accrued Interest Payable	478		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<a href="#">See Page 7 Attachment</a>	158,977		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 366,769	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	9,203,663		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>	\$ 9,203,663	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 9,570,432	\$	45
46	<b>TOTAL EQUITY</b>	\$ (369,740)	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 9,200,692	\$	47

\*(See instructions.)

Facility Name: CHURCHVIEW SUPPORTVE LVG CTR

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	\$ 2,787,144	1
2	Discounts and Allowances	(28,674)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 2,758,470</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services	81,676	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 81,676</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	33,207	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 33,207</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	See Page 8 Attachment	6,595	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 6,595</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 2,879,948</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	1,030,653	19
20	Health Care/ Personal Care	474,966	20
21	General Administration	1,087,473	21
<b>B. Capital Expense</b>			
22	Ownership	841,636	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>\$ 3,434,728</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (554,780)</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>\$ (554,780)</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 2,008,659	32
33	Private Pay - Net Inpatient Revenue	749,811	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 2,758,470</b>	<b>37</b>



**Balance Sheet PG 7 Other**

Balance Sheet

Other Current Assets Detail		Amt
1102-9971-0-0	A/R-Employee Advance	-
1102-9972-0-0	A/R-Gardant Mgmt Solutions	-
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	3,484
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>3,484</b>

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	-
<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	12,900
2112-0101-0-0	Accrued Partnership Mgmt Fee	53,000
2112-0102-0-0	Accrued Incentive Mgmt Fee	-
2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
2112-0105-0-0	Accrued Liabilities	67,413
2112-0110-0-0	Accrued Insurance	-
2112-0115-0-0	Accrued Developer Fee	-
2112-0130-0-0	Accrued MIP	-
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	10,601
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	15,063
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>158,977</b>

**Income Statement PG 8 Other**

Income Statement

Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	2,310 Late Fee, NSF
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	4,285
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-

<b>PG8-15.1</b>	<b>6,595</b>
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