

		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.

I. Facility ID Number: 1000074

Facility Name: Joshua Arms of LSSI

Address: 1315 Rowell Avenue Joliet 60433

County: Will

Telephone Number: (815) 722-6401 Fax # (815) 727-6477

Federal Employer ID Number:

Date Current Owners were Certified: 7/1/2014

Type of Ownership:

X

VOLUNTARY, NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: Steven N. Lavenda

Telephone Number: (847) 282 - 6300

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2017 to 6/30/2018 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone)

(Date)

(Date)

Nine Parkway North, Suite 200 Deerfield, IL 60015

(847) 282-6300 Fax (847) 282-6301

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

Facility Name Joshua Arms of LSSI Report Period Beginning: 7/1/2017 Ending: 6/30/2018

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units N/A

	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	56	Single Unit Apartment	56	20,440	1
2		Double Unit Apartment			2
3		Other			3
4	56	TOTALS	56	20,440	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	14,048	925		14,973	5
6	Double Unit					6
7	Other					7
8	TOTALS	14,048	925		14,973	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 73.25%

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

95 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 ☐ NO

Tax Year: 6/30/2018 Fiscal Year: 6/30/2018

\* 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. N/A

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. N/A

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. N/A

## STATE OF ILLINOIS

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Facility Name: Joshua Arms of LSSI

Report Period Beginning:

7/1/2017

Ending:

6/30/2018

## 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	160,548	985	147,594	309,127	(54,366)	254,761	1
2	Housekeeping, Laundry and Maintenance	47,455	33,261	141,980	222,696	3,843	226,539	2
3	Heat and Other Utilities			10,539	10,539		10,539	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	208,003	34,246	300,113	542,362	(50,523)	491,839	5
	<b>B. Health Care and Programs</b>							
6	Health Care/ Personal Care	213,085	1,866	99,526	314,477		314,477	6
7	Activities and Social Services	31,978		4,648	36,626		36,626	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	245,063	1,866	104,174	351,103		351,103	9
	<b>C. General Administration</b>							
10	Administrative and Clerical	68,603	1,215	118,839	188,657	(87,505)	101,152	10
11	Marketing Materials, Promotions and Advertising	37,312		1,966	39,278		39,278	11
12	Employee Benefits and Payroll Taxes			313,273	313,273		313,273	12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	105,915	1,215	434,078	541,208	(87,505)	453,703	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	558,981	37,327	838,365	1,434,673	(138,028)	1,296,645	16
	<b>Capital Expenses</b>							
	<b>D. Ownership</b>							
17	Depreciation					303,671	303,671	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			71	71		71	21
22	Other (specify):	455,784	43,818	1,608,284	2,107,886	(2,108,312)	(426)	22
23	<b>TOTAL Ownership</b>	455,784	43,818	1,608,355	2,107,957	(1,804,641)	303,316	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	1,014,765	81,145	2,446,720	3,542,630	(1,942,669)	1,599,961	24

STATE OF ILLINOIS			Page 3A
Joshua Arms of LSSI			
Report Period Beginning:	7/1/2017		
Ending:	6/30/2018		
Sch. V Line			
NON-ALLOWABLE EXPENSES			
	Amount	Reference	
1 Non-Straight Line Depreciation	\$ 302,671	17	1
2 Guest Taxes/Employee Meals	(54,366)	01	2
3 Bad Debt Expense	(87,595)	10	3
4 Non-Reimbursable Section	(2,108,312)	22	4
5 Additional R&M	3,843	02	5
6			6
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97			97
98			98
99			99
100			100
101 Total	(1,942,669)		101

Facility Name: Joshua Arms of LSSI

Report Period Beginning 7/1/2017 Ending: 6/30/2018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses	1.42	29.82	2
3	Certified Nurse Assistants	4.44	13.49	3
4	Activity Director & Assistants	0.92	16.72	4
5	Social Service Workers			5
6	Head Cook	3.25	15.07	6
7	Cook Helpers/Assistants	2.27	12.41	7
8	Dishwashers			8
9	Maintenance Workers	0.08	25.25	9
10	Housekeepers	1.62	12.74	10
11	Laundry			11
12	Managers	0.26	41.08	12
13	Other Administrative	0.82	20.12	13
14	Clerical	0.47	12.74	14
15	Marketing	0.82	21.99	15
16	Other	9.79	22.38	16
17	Total (lines 1 thru 16)	26.17	\$ 18.64	17

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

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	N/A			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
Total		\$ 3

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Lutheran Social Services of IL		Des Plaines		Non-Profit	

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: Joshua Arms of LSSI Report Period Beginning: 7/1/2017 Ending: 6/30/2018

VIII. OWNERSHIP COSTS

A. Purchase price of land 25,714 Year land was acquired 1978

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	56		1978	1978	\$ 1,470,916	\$	40	\$ 36,773	\$ 36,773	\$ 1,469,812	1
2			2007	2007	6,220,763		25	248,831	248,831	2,726,557	2
3											3
4											4
5											5
	Improvement Type										
6	Total From Supplemental Page 5's				342,796			16,771	16,771	141,422	6
7	Various			1983	12,507		20				7
8	Various			1984	21,519		20				8
9	Various			1985	2,460		20				9
10	Various			1988	2,070		20			2,070	10
11	Various			1989	4,675		20			4,675	11
12	Various			1991	7,188		20			7,188	12
13	Various			1992	65,765		20			65,765	13
14	Various			1995	125,236		20			125,236	14
15	Various			1997	2,099		20			2,099	15
16	Various			1998	2,485		20			2,485	16
17	TOTAL (lines 1 thru 16)				\$ 8,280,479	\$		\$ 302,375	\$ 302,375	\$ 4,547,309	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	\$ 256,644	\$	\$ 1,297	1,297	7	\$ 244,976	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	\$ 256,644	\$	\$ 1,297	1,297		\$ 244,976	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	Moveable Equipment	\$ 786,839	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 786,839	\$	\$	24

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Various	2011	141,949		20	7,097	7,097	85,663	1
2	Hollow Metal Doors, Frames & Hardware	2012	2,714		20	136	136	1,457	2
3	Cla Valve & Associated Components	2014	2,715		20	136	136	543	3
4	Booster Pumps & Associated Components	2014	13,529		20	676	676	2,705	4
5	15 Ptac Units	2014	19,740		20	987	987	3,948	5
6	15 Ptac Units Replacement	2015	20,310		20	1,016	1,016	3,047	6
7	Windows Glass	2015	11,430		20	572	572	1,715	7
8	Removal & Replacement Of Hallway Carpet	2016	11,276		20	564	564	1,691	8
9	Replacement Of Kitchen Rooftop Unit	2017	10,200		20	510	510	510	9
10	15 Ptac Units - Heating/Cooling	2017	18,610		20	931	931	931	10
11	Exhaust Fan Replacement	2018	11,235		20	562	562	562	11
12	Roof Replacement	2018	23,199		20	1,160	1,160	1,160	12
13	Camera Systems Upgrade	2018	16,018		20	801	801	801	13
14									14
15									15
16									16
17									17
18									18
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 302,925	\$		\$ 15,146	\$ 15,146	\$ 104,732	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name: Joshua Arms of LSSI

Report Period Beginning: 7/1/2017

Ending: 6/30/2018

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

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

9. Rental amount for movable equipment \$ 71

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	Assisted Living Conversion			Conversion of 56 units to assisted living		\$ 6,339,159	\$ 3,783,151	7/1/39		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 6,339,159	\$ 3,783,151			\$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 6,339,159	\$ 3,783,151			\$	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.

## STATE OF ILLINOIS

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Facility Name: Joshua Arms of LSSI

Report Period Beginning: 7/1/2017

Ending: 6/30/2018

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2018

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 150,135	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	421,437		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,443		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 574,015	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,800		13
14	Buildings, at Historical Cost	12,616,049		14
15	Leasehold Improvements, at Historical Cost	1,936,775		15
16	Equipment, at Historical Cost	1,040,093		16
17	Accumulated Depreciation (book methods)	(11,594,267)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,940,997		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>	\$ 7,051,447	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 7,625,462	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 457,533	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	518,326		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36	<u>See Attached</u>	27,275		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 1,003,134	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,154,840		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43	<u>See Attached</u>	3,891,305		43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 11,046,145	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 12,049,279	\$	45
46	<b>TOTAL EQUITY</b>	\$ (4,423,817)	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 7,625,462	\$	47

\*(See instructions.)

Facility Name: Joshua Arms of LSSI

Report Period Beginning: 7/1/2017

Ending:

6/30/2018

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

		1	
	<b>I. Revenue</b>	<b>Amount</b>	
	<b>A. SLF Resident Care</b>		
1	Gross SLF Resident Revenue	\$ 1,592,472	1
2	Discounts and Allowances	(88,993)	2
	<b>SUBTOTAL Resident Care</b>		
3	(line 1 minus line 2)	\$ 1,503,479	3
	<b>B. Other Operating Revenue</b>		
4	Special Services		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	54,366	9
10	Laundry		10
	<b>SUBTOTAL OTHER OPERATING REVENUE</b>		
11	(sum of lines 4 thru 10)	\$ 54,366	11
	<b>C. Non-Operating Revenue</b>		
12	Contributions		12
13	Interest and Other Investment Income		13
	<b>SUBTOTAL Non-Operating Revenue</b>		
14	(sum of lines 12 and 13)	\$	14
	<b>D. Other Revenue (specify):</b>		
15	Non-Reimbursable Section	2,321,941	15
16			16
	<b>SUBTOTAL Other Revenue</b>		
17	(sum of lines 15 and 16)	\$ 2,321,941	17
	<b>TOTAL REVENUE</b>		
18	(sum of lines 3, 11, 14 and 17)	\$ 3,879,786	18

		2	
	<b>II. Expenses</b>	<b>Amount</b>	
	<b>A. Operating Expenses</b>		
19	General Services	542,362	19
20	Health Care/ Personal Care	351,103	20
21	General Administration	541,208	21
	<b>B. Capital Expense</b>		
22	Ownership	2,107,957	22
	<b>C. Other Expenses</b>		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
	<b>TOTAL EXPENSES</b>		
28	(sum of lines 19 thru 27)	\$ 3,542,630	28
	<b>Income Before Income Taxes</b>		
29	(line 18 minus line 28)	\$ 337,156	29
30	<b>Income Taxes</b>	\$	30
	<b>NET INCOME OR LOSS FOR THE YEAR</b>		
31	(line 29 minus line 30)	\$ 337,156	31
	<b>III. Net Resident Care Revenue detailed by Payer Source</b>		
32	Medicaid - Net Inpatient Revenue	\$ 261,729	32
33	Private Pay - Net Inpatient Revenue	652,436	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Ins - Managed Care</u>	589,314	35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	\$ 1,503,479	37