

		FOR BHF USE			

LL2

Supportive Living Facility

**2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2014)**

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: 1000051

Facility Name: Springfield SLC

Address: 2034 Clearlake Ave Springfield 62702
Number City Zip Code

County: Sangamon

Telephone Number: (217) 522-8843 Fax # _____

Federal Employer ID Number: _____

Date Current Owners were Certified: 8/3/2005

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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 _____	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2014 to 12/31/2014 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) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C. 111 Pfungsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax <u>(847) 236-1155</u>	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda Telephone Number: (847) 236 - 1111
Email Address: _____

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 Springfield Slc

Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	121	Single Unit Apartment	121	44,165	1
2	14	Double Unit Apartment	14	5,110	2
3		Other			3
4	135	TOTALS	135	49,275	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	26,082	4,978		31,060	5
6	Double Unit	3,018	576		3,594	6
7	Other					7
8	TOTALS	29,100	5,554		34,654	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 70.33%

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

Not tracked Also, indicate the number of unpaid bed-hold days the SLF had during this year. Not tracked (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)

None

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/14 Fiscal Year: 12/31/14

* 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. 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? N/A

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? N/A

If no, explain. N/A

Facility Name: Springfield Slc

Report Period Beginning:

1/1/2014

Ending: 12/31/2014

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	184,735	286,422	960	472,117		472,117	1
2	Housekeeping, Laundry and Maintenance	154,288	24,506	73,986	252,780	15,979	268,759	2
3	Heat and Other Utilities			177,609	177,609	(30,969)	146,640	3
4	Other (specify):							4
5	TOTAL General Services	339,023	310,928	252,555	902,506	(14,990)	887,516	5
B. Health Care and Programs								
6	Health Care/ Personal Care	451,993	13,070	3,600	468,663		468,663	6
7	Activities and Social Services	50,535	12,224	11,885	74,644	(245)	74,399	7
8	Other (specify): Barber & Beauty			5,351	5,351		5,351	8
9	TOTAL Health Care and Programs	502,528	25,294	20,836	548,658	(245)	548,413	9
C. General Administration								
10	Administrative and Clerical	190,988	11,666	183,101	385,755	(48,669)	337,086	10
11	Marketing Materials, Promotions and Advertising	45,829		57,377	103,206		103,206	11
12	Employee Benefits and Payroll Taxes			229,731	229,731		229,731	12
13	Insurance-Property, Liability and Malpractice			28,729	28,729	38,700	67,429	13
14	Other (specify):							14
15	TOTAL General Administration	236,817	11,666	498,938	747,421	(9,969)	737,452	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,078,368	347,888	772,329	2,198,585	(25,204)	2,173,381	16
Capital Expenses								
D. Ownership								
17	Depreciation			17,676	17,676	253,892	271,568	17
18	Interest			58,064	58,064	391,217	449,281	18
19	Real Estate Taxes			209	209	72,000	72,209	19
20	Rent -- Facility and Grounds			686,000	686,000	(686,000)		20
21	Rent -- Equipment			1,138	1,138		1,138	21
22	Other (specify):							22
23	TOTAL Ownership			763,087	763,087	31,109	794,196	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,078,368	347,888	1,535,416	2,961,672	5,905	2,967,577	24

Springfield Sls

Report Period Beginning: 1/1/2014
 Ending: 12/31/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
			Reference
1	Non-Straight Line Depreciation	(43,934)	17
2	Additional R&M	15,979	02
3	Misc Income	(201)	10
4	Income - Activities	(245)	07
5	Interest Income	(2)	18
6	Cable TV	(30,969)	03
7	Bank Charges	(1,231)	10
8	Charitable Contributions	(30)	10
9	Bad Debts	(42,714)	10
10	Penalties & Fines	(816)	10
11	Prior Year Expense	(3,677)	10
12			12
13	Building Co. - Rent Income	(686,000)	20
14	Building Co. - Depreciation	297,826	17
15	Building Co. - Insurance	38,700	13
16	Building Co. - Interest Expense	391,219	18
17	Building Co. - Real Estate Taxes	72,000	19
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
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84			84
85			85
86			86
87			87
88			88
89			89
90			90
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92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	5,905	101

Facility Name: Springfield Slc

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.84	\$ 26.00	1
2	Licensed Practical Nurses	1.10	20.87	2
3	Certified Nurse Assistants	14.06	10.43	3
4	Activity Director & Assistants	1.99	12.19	4
5	Social Service Workers			5
6	Head Cook	1.03	20.11	6
7	Cook Helpers/Assistants	6.72	10.12	7
8	Dishwashers			8
9	Maintenance Workers	1.85	16.74	9
10	Housekeepers	3.55	12.16	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.00	32.82	13
14	Clerical	4.20	14.06	14
15	Marketing	1.00	22.03	15
16	Other			16
17	Total (lines 1 thru 16)	38.35	\$ 13.52	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	Healthcare Development, LLC			\$	1
2		17%		96,000	2
3					3
4					4
5					5
Total				\$ 96000	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee		
1	\$	1	
2		2	
Total		\$	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
Springfield Property, LLC				Building Co.	

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: N/A If yes, what is the value of those services? \$ N/A

(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: Springfield Slc

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land 115,071 Year land was acquired _____

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	135		2005	2005	\$ 8,063,935	\$ 297,826	35	\$ 230,398	\$ (67,428)	\$ 2,372,053	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Total From Supplemental Page 5's				193,203	17,676		9,360	(8,316)	28,129	6
7	Various		2005		1,750		20	88	88	795	7
8	Various		2006		3,321		20	166	166	1,465	8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 8,262,209	\$ 315,502		\$ 240,012	\$ (75,490)	\$ 2,402,442	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	\$ 319,793	\$	\$ 31,556	31,556	10	\$ 211,378	18
19	Vehicles	43,071				5	43,071	19
20	TOTAL (lines 18 and 19)	\$ 362,864	\$	\$ 31,556	31,556		\$ 254,449	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 & ID Number Springfield Slc

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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

1	2	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	Carbon Monoxide Detectors	2007	2,632		20	132	132	1,053	2
3	Elevator - Upgrade To Code	2008	4,900		20	245	245	1,572	3
4	Concrete Sidewalk	2009	6,762		20	338	338	1,719	4
5	Paint / Wallpaper	2009	5,796		20	290	290	1,497	5
6	Water Damage Repair	2010	4,404		20	220	220	1,046	6
7	Improvements	2010	11,419		20	571	571	2,331	7
8	Fire Pump	2011	2,936		20	147	147	587	8
9	Security Cameras / Installation	2011	8,136		20	407	407	1,458	9
10	Carpet	2011	3,046		20	152	152	609	10
11	2Nd Floor Dining Room Remodel	2011	19,726		20	986	986	3,041	11
12	Exit Alarms	2012	3,994		20	200	200	416	12
13	2Nd Floor Remodel-Chair Rail, Electrical, Window Treatments, Fire	2012	49,947		20	2,497	2,497	7,284	13
14	3Rd Floor Activity Room Remodel	2012	3,200		20	160	160	427	14
15	Carpet	2012	7,984		20	399	399	998	15
16	Front Door Awning	2012	2,867		20	143	143	358	16
17	Wall / Door Addition To Front Office	2012	2,860		20	143	143	298	17
18	7 Ptac Heat Pump	2013	5,955		20	298	298	571	18
19	Security Cameras	2013	5,626		20	281	281	469	19
20	Outside Security Cameras	2013	6,048		20	302	302	378	20
21	Stairwell Heaters	2013	2,990		20	150	150	162	21
22	Carpet Replacement In Resident Rooms	2013	6,446		20	322	322	376	22
23	Demolition Of House On Lot	2013	6,000		20	300	300	575	23
24	Light Bars For Elevator	2013	3,367		20	168	168	309	24
25	Remodel Suite On 5Th Floor	2013	2,986		20	149	149	236	25
26	Replacement Pump For Fire Sprinkler	2014	3,382		20	169	169	169	26
27	Repair Balcony / Railings On Building	2014	3,215		20	80	80	80	27
28	Flooring 1St Floor Activity Room	2014	6,579		20	110	110	110	28
29									29
30									30
31									31
32									32
33	Total Book Depreciation			17,676			(17,676)		33
34	TOTAL (lines 1 thru 33)		\$ 193,203	\$ 17,676		\$ 9,360	\$ (8,316)	\$ 28,129	34

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

Facility Name & ID Number Springfield Slc

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
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 & ID Number Springfield Slc

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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							
2							
3							
4							
5							
6							
7							
8							
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29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$

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

Facility Name: Springfield Slc

Report Period Beginning: 1/1/2014

Ending: 2/31/2014

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 \$ 1,138

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	Signumd Leftkovitz		X	Operating line of credit	1/1/12	\$ 2,464,263	\$ 2,287,824	1/1/41	2.5000	\$ 58,064	1
2	Beech Street		X	Mortgage	/ /		7,355,850	/ /		391,219	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 2,464,263	\$ 9,643,674			\$ 449,283	7
	B. Non-Facility Related										
8	Interest Income		X		/ /			/ /		(2)	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 2,464,263	\$ 9,643,674			\$ 449,281	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.

Facility Name: Springfield Slc

Report Period Beginning: 1/1/2014

Ending:

12/31/2014

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 51,431	\$ 143,941	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	17,067	(8,671)	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,717	9,717	6
7	Other Prepaid Expenses	13,469	13,469	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	464	297,696	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 92,148	\$ 456,152	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		141,173	13
14	Buildings, at Historical Cost		8,091,365	14
15	Leasehold Improvements, at Historical Cost	144,994	144,994	15
16	Equipment, at Historical Cost	262,213	466,795	16
17	Accumulated Depreciation (book methods)	(248,923)	(3,215,099)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		202,111	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(37,896)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	457,408	457,408	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 615,692	\$ 6,250,851	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 707,840	\$ 6,707,003	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 121,312	\$ 121,312	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	58,641	58,641	30
31	Accrued Taxes Payable	9,319	9,319	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36	See Attached		1,500,933	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 189,272	\$ 1,690,205	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	2,287,824	2,287,824	38
39	Mortgage Payable		7,355,850	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)	\$ 2,287,824	\$ 9,643,674	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,477,096	\$ 11,333,879	45
46	TOTAL EQUITY	\$ (1,769,256)	\$ (4,626,876)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 707,840	\$ 6,707,003	47

*(See instructions.)

Facility Name: Springfield Slc

Report Period Beginning: 1/1/2014

Ending:

12/31/2014

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 2,925,025	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,925,025	3
B. Other Operating Revenue			
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		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	2	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2	14
D. Other Revenue (specify):			
15	See Attached	446	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 446	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,925,473	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	902,506	19
20	Health Care/ Personal Care	548,658	20
21	General Administration	747,421	21
B. Capital Expense			
22	Ownership	763,087	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 2,961,672	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (36,199)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (36,199)	31