

		FOR BHF USE			

LL2

Supportive Living Facility
2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2005)

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.</p> <p>Facility Name: <u>Concord Place</u></p> <p>Address: <u>401 West Lake</u> <u>Northlake</u> <u>60164</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 562-9000</u> Fax # <u>(708) 409-2750</u></p> <p>Federal Employer ID Number: <u>36-3489309</u></p> <p>Date Current Owners were Certified: <u>4/10/2003</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" 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 checked="" 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>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u></p>	<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 checked="" 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>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>1/1/2005</u> to <u>12/31/2005</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 border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title)</td> <td><u>Steven N. Lavenda, C.P.A.</u></td> </tr> <tr> <td>(Firm Name & Address)</td> <td><u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td>(Telephone)</td> <td><u>(847) 236-1111</u> Fax <u>(847) 236-1155</u></td> </tr> </table> <p align="center">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) _____			(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.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone)	<u>(847) 236-1111</u> Fax <u>(847) 236-1155</u>
<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 checked="" 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 _____																																									
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.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>																																								
	(Telephone)	<u>(847) 236-1111</u> Fax <u>(847) 236-1155</u>																																								

Facility Name Concord Place

Report Period Beginning: 1/1/2005 Ending: 12/31/2005

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	124	Single Unit Apartment	124	45,260	1
2	20	Double Unit Apartment	20	7,300	2
3		Other			3
4	144	TOTALS	144	52,560	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	23,360	4,015		27,375	5
6	Double Unit	365	1,095		1,460	6
7	Other					7
8	TOTALS	23,725	5,110		28,835	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 54.86%

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

Independent Living Apartments, Banquet Facilities

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* 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: Concord Place

Report Period Beginning:

1/1/2005

Ending: 12/31/2005

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	496,624	400,006	32,849	929,479	(556,615)	372,864	1
2	Housekeeping, Laundry and Maintenance	235,808	62,347	279,002	577,157	(392,784)	184,373	2
3	Heat and Other Utilities			831,226	831,226	(565,234)	265,992	3
4	Other (specify):							4
5	TOTAL General Services	732,432	462,353	1,143,077	2,337,862	(1,514,633)	823,229	5
B. Health Care and Programs								
6	Health Care/ Personal Care	304,936	1,819	671	307,426		307,426	6
7	Activities and Social Services	80,415		7,879	88,294	(50,328)	37,966	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	385,351	1,819	8,550	395,720	(50,328)	345,392	9
C. General Administration								
10	Administrative and Clerical	239,808	14,578	736,918	991,304	(863,602)	127,702	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			305,757	305,757	(127,001)	178,756	12
13	Insurance-Property, Liability and Malpractice			385,165	385,165	(359,723)	25,442	13
14	Other (specify):							14
15	TOTAL General Administration	239,808	14,578	1,427,840	1,682,226	(1,350,326)	331,900	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,357,591	478,750	2,579,467	4,415,808	(2,915,287)	1,500,521	16
Capital Expenses								
D. Ownership								
17	Depreciation			498,929	498,929	(326,348)	172,581	17
18	Interest			831,557	831,557	(713,061)	118,496	18
19	Real Estate Taxes			143,978	143,978	(97,905)	46,073	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			2,595	2,595	(1,765)	830	21
22	Other (specify): Amortization of Loan Costs			5,151	5,151	(3,503)	1,648	22
23	TOTAL Ownership			1,482,210	1,482,210	(1,142,582)	339,628	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,357,591	478,750	4,061,677	5,898,018	(4,057,869)	1,840,149	24

Facility Name: Concord Place

Report Period Beginning: 1/1/2005 Ending: 12/31/2005

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.42	\$ 19.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	12.16	9.84	3
4	Activity Director & Assistants	2.01	19.20	4
5	Social Service Workers			5
6	Head Cook	1.75	11.62	6
7	Cook Helpers/Assistants	25.62	7.52	7
8	Dishwashers	3.89	6.62	8
9	Maintenance Workers	4.22	13.84	9
10	Housekeepers	6.60	8.30	10
11	Laundry	0.02	8.30	11
12	Managers			12
13	Other Administrative	1.00	69.23	13
14	Clerical	4.45	10.35	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	63.15	\$ 10.34	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	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

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 <u>1</u>	City <u>2</u>
N/A	

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
F&F Realty	Skokie, IL	Management

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? \$ _____
 (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: Concord Place

Report Period Beginning: 1/1/2005

Ending: 12/31/2005

VIII. OWNERSHIP COSTS

A. Purchase price of land 201,301 Year land was acquired 1986

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	164		1986	1974	\$ 1,151,851	\$ 143,981	35	\$ 32,910	\$ (111,071)	\$ 691,111	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Total From Page 5A				402,051	273,997		20,103	(253,894)	147,132	6
7	Limp			2000	646,883		20	32,344	32,344	194,065	7
8	Carpet			2000	38,577		20	1,929	1,929	11,573	8
9	Limp			2001	167,645		20	8,382	8,382	41,911	9
10	Carpet			2001	7,444		20	372	372	1,861	10
11	Limp			2002	581,348		20	29,067	29,067	116,270	11
12	Carpet			2002	12,204		20	610	610	2,441	12
13	Signs			2002	1,492		20	75	75	298	13
14	Limp			2003	415,573		20	20,779	20,779	62,336	14
15	Carpet			2003	14,478		20	724	724	2,172	15
16	Carpet			2003	5,224		20	261	261	784	16
17	TOTAL (lines 1 thru 16)				\$ 3,444,770	\$ 417,978		\$ 147,556	\$ (270,422)	\$ 1,271,953	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	\$ 226,268	\$ 75,405	\$ 22,251	(53,154)	10	\$ 105,545	18	
19	Vehicles	30,715	5,546	2,774	(2,772)	5	24,633	19	
20	TOTAL (lines 18 and 19)		\$ 256,982	\$ 80,951	\$ 25,025		(55,926)	\$ 130,178	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	Non-Care	\$ 8,343,789	\$ -	\$ -	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 8,343,789	\$ -	\$ -	24

Facility Name & ID Number Concord Place

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

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	2003	1,188		20	59	59	178	2
3	2003	161		20	8	8	24	3
4	2004	7,525		20	376	376	753	4
5	2004	154		20	8	8	15	5
6	2004	171		20	9	9	17	6
7	2005	59,493		20	2,975	2,975	2,975	7
8	1988	33,891		20	1,695	1,695	30,502	8
9	1991	3,461		20	173	173	2,596	9
10	1992	2,960		20	148	148	2,072	10
11	1995	2,858		20	143	143	1,572	11
12	1996	2,534		20	127	127	1,267	12
13	1996	8,885		20	444	444	4,443	13
14	1997	7,873		20	394	394	3,543	14
15	1997	1,281		20	64	64	576	15
16	1998	6,842		20	342	342	2,737	16
17	1998	26,280		20	1,314	1,314	10,512	17
18	1998	11,571		20	579	579	4,628	18
19	1999	195,453		20	9,773	9,773	68,408	19
20	1999	29,471		20	1,474	1,474	10,315	20
21								21
22								22
23			273,997			(273,997)		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)	\$ 402,051	\$ 273,997		\$ 20,103	\$ (253,894)	\$ 147,132	34

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

Facility Name: Concord Place

Report Period Beginning: 1/1/2005

Ending: 2/31/2005

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 NO9. Rental amount for movable equipment \$ 830

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	MidNorth		X	Mortgage	/ /	\$	\$ 1,456,784	/ /		\$ 118,113	1
2	Midwest Bank		X	Mortgage	/ /		3,659,000	/ /		251,492	2
3	Chrysler Corp		X	Auto	/ /		6,066	/ /		701	3
	Working Capital										
4	Corus Bank		X	Phone System	/ /		43,261	/ /		2,481	4
5	Canon Financial		X	Copier	/ /		1,092	/ /		356	5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	\$ 5,166,203			\$ 373,143	7
	B. Non-Facility Related										
8	Interest Income				/ /			/ /		-2,843	8
9	Allocation to Non-Care				/ /			/ /		-251,804	9
10	TOTALS (lines 7, 8 and 9)					\$	\$ 5,166,203			\$ 118,496	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: Concord Place

Report Period Beginning: 1/1/2005

Ending:

12/31/2005

12/31/2005

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 619,700	\$	1
2	Cash-Patient Deposits	3,027		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	628,857		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,896		6
7	Other Prepaid Expenses	10,734		7
8	Accounts Receivable (owners or related parties)	1,000		8
9	Other(specify): See Attached	611,164		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,887,378	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	629,065		13
14	Buildings, at Historical Cost	3,722,611		14
15	Leasehold Improvements, at Historical Cost	7,051,543		15
16	Equipment, at Historical Cost	862,282		16
17	Accumulated Depreciation (book methods)	(5,859,418)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	111,585		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,517,668	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,405,046	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 238,296	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,975		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	166,100		31
32	Accrued Interest Payable	1,787,254		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
Other Current Liabilities(specify):				
35				35
36	See Attached	481,610		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 2,740,235	\$	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable	3,709,419		38
39	Mortgage Payable	1,456,784		39
40	Bonds Payable			40
41	Deferred Compensation			41
Other Long-Term Liabilities(specify):				
42				42
43	See Attached	12,931,985		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 18,098,188	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 20,838,423	\$	45
46	TOTAL EQUITY	\$ (12,433,377)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,405,046	\$	47

*(See instructions.)

Facility Name: Concord Place

Report Period Beginning: 1/1/2005

Ending:

12/31/2005

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	\$ 6,236,726	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 6,236,726	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop	3,189	7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry	8,618	10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 11,807	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	2,843	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 2,843	14
D. Other Revenue (specify):			
15	See Attached	2,402,270	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 2,402,270	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 8,653,646	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	2,337,862	19
20	Health Care/ Personal Care	395,720	20
21	General Administration	1,682,226	21
B. Capital Expense			
22	Ownership	1,482,210	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	Banquet Expenses	1,428,915	26
27	Marketing Expenses	263,422	27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 7,590,355	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 1,063,291	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 1,063,291	31