

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2010  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2010)**

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>1000072</u></p> <p><b>Facility Name:</b> <u>Magnolia Terrace</u></p> <hr/> <p><b>Address:</b> <u>623 Hamacher Street</u> <u>Waterloo</u> <u>62298</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>Monroe</u></p> <p><b>Telephone Number:</b> ( <u>618</u> ) <u>939-3488</u> Fax # ( <u>618</u> ) <u>939-5030</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>11/14/1950</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input checked="" type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>Ken Marx</u> <b>Telephone Number:</b> ( <u>314</u> ) <u>231-5544</u></p> <p><b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" 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 checked="" 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>12/1/2009</u> to <u>11/30/2010</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 align="center"><b>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;"><b>Officer or Administrator of Provider</b></td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><b>Paid Preparer</b></td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) <u>Ken Marx</u> <u>Partner</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name &amp; Address) <u>BKD, LLP</u> <u>211 N Broadway, Suite 600, St. Louis MO 63102</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) ( <u>314</u> ) <u>231-5544</u> Fax # ( <u>314</u> ) <u>231-9731</u></td> <td style="border: none;"></td> </tr> </table> <p align="right"><b>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</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		<b>Paid Preparer</b>	(Signed) _____	(Date) _____		(Print Name and Title) <u>Ken Marx</u> <u>Partner</u>			(Firm Name & Address) <u>BKD, LLP</u> <u>211 N Broadway, Suite 600, St. Louis MO 63102</u>			(Telephone) ( <u>314</u> ) <u>231-5544</u> Fax # ( <u>314</u> ) <u>231-9731</u>	
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Facility Name Magnolia Terrace

Report Period Beginning: 12/1/2009 Ending: 11/30/2010

**III. STATISTICAL DATA**

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

Date of change in certified units 12/1/2007

	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	43	Single Unit Apartment	43	15,695	1
2	7	Double Unit Apartment	7	2,555	2
3		Other			3
4	50	TOTALS	50	18,250	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	5,954	8,987		14,941	5
6	Double Unit	365	2,190		2,555	6
7	Other					7
8	TOTALS	6,319	11,177		17,496	8

**C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.)** 95.87%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 695 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)**

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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: 11/30/10 Fiscal Year: 11/30/10

\* 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. No loans outstanding

**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. No loans outstanding

**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. No loans outstanding

Facility Name: Magnolia Terrace

Report Period Beginning:

12/1/2009

Ending: 11/30/2010

## 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	69,086	96,210		165,296		165,296	1
2	Housekeeping, Laundry and Maintenance	47,394	17,414		64,808		64,808	2
3	Heat and Other Utilities			124,250	124,250		124,250	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>116,480</b>	<b>113,624</b>	<b>124,250</b>	<b>354,354</b>		<b>354,354</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	224,039	98	250	224,387		224,387	6
7	Activities and Social Services	34,700			34,700		34,700	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>258,739</b>	<b>98</b>	<b>250</b>	<b>259,087</b>		<b>259,087</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	105,662		477,914	583,576		583,576	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			178,298	178,298		178,298	12
13	Insurance-Property, Liability and Malpractice			45,743	45,743		45,743	13
14	Other (specify): Travel, Training, Misc.			2,992	2,992		2,992	14
15	<b>TOTAL General Administration</b>	<b>105,662</b>		<b>704,947</b>	<b>810,609</b>		<b>810,609</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>480,881</b>	<b>113,722</b>	<b>829,447</b>	<b>1,424,050</b>		<b>1,424,050</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			12,995	12,995		12,995	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>12,995</b>	<b>12,995</b>		<b>12,995</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>480,881</b>	<b>113,722</b>	<b>842,442</b>	<b>1,437,045</b>		<b>1,437,045</b>	<b>24</b>

Facility Name: Magnolia Terrace

Report Period Beginning: 12/1/2009 Ending: 11/30/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.35	\$ 27.36	1
2	Licensed Practical Nurses	0.14	20.72	2
3	Certified Nurse Assistants	7.02	13.74	3
4	Activity Director & Assistants	1.00	12.70	4
5	Social Service Workers			5
6	Head Cook	1.50	10.66	6
7	Cook Helpers/Assistants	2.00	8.62	7
8	Dishwashers			8
9	Maintenance Workers	0.75	11.90	9
10	Housekeepers	1.74	9.25	10
11	Laundry			11
12	Managers	1.00	26.64	12
13	Other Administrative	0.28	43.71	13
14	Clerical	1.00	10.93	14
15	Marketing	0.28	22.04	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>17.06</b>	<b>\$ 18.76</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>

**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>
Oak Hill	Waterloo

**VI. (B) Management fees paid to unrelated parties**

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$</b>
		<b>3</b>

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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: Magnolia Terrace

Report Period Beginning:

12/1/2009

Ending:

11/30/2010

**VIII. OWNERSHIP COSTS**

A. Purchase price of land \_\_\_\_\_ 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			2007	2007	\$ 7,707,025	\$ 106,469	7	\$ 106,469	\$	\$ 425,876	1
2											2
3											3
4											4
5											5
	<b>Improvement Type</b>										
6		Light Fixtures		2007	1,644	235	7	235		940	6
7		Laundry Room		2007	1,145	164	7	164		656	7
8		Washer & Dryer		2007	1,280	183	7	183		732	8
9		Glass Tinting		2008	1,395	199	7	199		597	9
10		Bird Aviary		2009	5,304	354	15	354		708	10
11		BT Floor - Dining Room Floor		2009	7,395		7				11
12		Panic Button		2007	1,341	268	5	268		804	12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 7,726,529	\$ 107,872		\$ 107,872	\$	\$ 430,313	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	\$ N/A	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)		\$	\$	\$		\$	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		\$ N/A	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)		\$	\$	24

Facility Name: Magnolia Terrace

Report Period Beginning: 12/1/2009

Ending: 1/30/2010

**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 \$ N/A

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**

	Name of Lender	2		3	4	6		7	8	9					
		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					/ /	\$	\$	/ /		\$	1				
2					/ /			/ /			2				
3					/ /			/ /			3				
	<b>Working Capital</b>														
4					/ /			/ /			4				
5					/ /			/ /			5				
6					/ /			/ /			6				
7	<b>TOTAL Facility Related</b>					\$	\$			\$	7				
	<b>B. Non-Facility Related</b>														
8					/ /			/ /			8				
9					/ /			/ /			9				
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	\$			\$	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: Magnolia Terrace

Report Period Beginning: 12/1/2009

Ending:

11/30/2010

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2010

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$ 2,841,856	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )		1,733,975	3
4	Supply Inventory (priced at )		34,113	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		30,932	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		797,459	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$ 5,438,335	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		6,849,756	14
15	Leasehold Improvements, at Historical Cost		(4,707,767)	15
16	Equipment, at Historical Cost		1,398,891	16
17	Accumulated Depreciation (book methods)		(1,332,316)	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):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 2,208,564	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$ 7,646,899	25

\*(See instructions.)

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$ 163,973	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		418,208	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<b>Other Liabilities</b>		17,326	35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$	\$ 599,507	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42	<b>Other Long Term Liabilities</b>		946,598	42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$	\$ 946,598	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$	\$ 1,546,105	45
46	<b>TOTAL EQUITY</b>	\$	\$ 6,100,794	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$	\$ 7,646,899	47

Facility Name: Magnolia Terrace

Report Period Beginning: 12/1/2009

Ending:

11/30/2010

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 1,735,019	1
2	Discounts and Allowances	(195,965)	2
<b>SUBTOTAL Resident Care</b>			
3	(line 1 minus line 2)	\$ 1,539,054	3
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services	227	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	2,200	8
9	Non-Resident Meals		9
10	Laundry		10
<b>SUBTOTAL OTHER OPERATING REVENUE</b>			
11	(sum of lines 4 thru 10)	\$ 2,427	11
<b>C. Non-Operating Revenue</b>			
12	Contributions	(5)	12
13	Interest and Other Investment Income		13
<b>SUBTOTAL Non-Operating Revenue</b>			
14	(sum of lines 12 and 13)	\$ (5)	14
<b>D. Other Revenue (specify):</b>			
15	Food Stamp Revenue	23,159	15
16	NH Revenue	8,946,771	16
<b>SUBTOTAL Other Revenue</b>			
17	(sum of lines 15 and 16)	\$ 8,969,930	17
<b>TOTAL REVENUE</b>			
18	(sum of lines 3, 11, 14 and 17)	\$ 10,511,406	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	354,354	19
20	Health Care/ Personal Care	259,087	20
21	General Administration	810,609	21
<b>B. Capital Expense</b>			
22	Ownership	12,995	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	NH Expenses	8,578,591	26
27			27
<b>TOTAL EXPENSES</b>			
28	(sum of lines 19 thru 27)	\$ 10,015,636	28
<b>Income Before Income Taxes</b>			
29	(line 18 minus line 28)	\$ 495,770	29
<b>Income Taxes</b>			
30		\$	30
<b>NET INCOME OR LOSS FOR THE YEAR</b>			
31	(line 29 minus line 30)	\$ 495,770	31