

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2012  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2012)**

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>1000133</u></p> <p><b>Facility Name:</b> <u>Courtyard Estates of Peoria</u></p> <p><b>Address:</b> <u>117 North Western Avenue</u> <u>Peoria</u> <u>61604</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Peoria</u></p> <p><b>Telephone Number:</b> ( <u>309</u> ) <u>674-2400</u> Fax # <u>(309) 621-4860</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>8/24/11</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <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><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" 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>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309) 691-8113</u>  <b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" 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>1/1/2012</u> to <u>12/31/2012</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%; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td>                 (Signed) _____                  (Type or Print Name) <u>Mark B. Petersen</u>                  (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="vertical-align: top;"> <b>Paid Preparer</b> </td> <td>                 (Signed) _____                  (Date) _____                  (Print Name and Title) _____                  (Firm Name &amp; Address) _____                  (Telephone) ( <u>    </u> ) _____ Fax # ( <u>    </u> ) _____             </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) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	<b>Paid Preparer</b>	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( <u>    </u> ) _____ Fax # ( <u>    </u> ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name Courtyard Estates of Peoria

Report Period Beginning: 1/1/2012 Ending: 12/31/2012

**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	100	Single Unit Apartment	100	36,500	1
2		Double Unit Apartment			2
3		Other			3
4	100	TOTALS	100	36,500	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	19,074	8,718		27,792	5
6	Double Unit					6
7	Other					7
8	TOTALS	19,074	8,718		27,792	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 76.14%

**D. Indicate the number of paid bed-hold days the SLF had during this year**  
None Also, indicate the number of unpaid bed-hold days the SLF had during this year. None (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)

N/A

**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

\* 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: Courtyard Estates of Peoria

Report Period Beginning:

1/1/2012

Ending: 12/31/2012

## 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	138,696	187,066		325,762	(3,957)	321,805	1
2	Housekeeping, Laundry and Maintenance	176,988	42,840	36,530	256,358		256,358	2
3	Heat and Other Utilities			137,684	137,684		137,684	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>315,684</b>	<b>229,906</b>	<b>174,214</b>	<b>719,804</b>	<b>(3,957)</b>	<b>715,847</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	424,209	2,498	10	426,717		426,717	6
7	Activities and Social Services	46,839	862	1,765	49,466	(5,109)	44,357	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>471,048</b>	<b>3,360</b>	<b>1,775</b>	<b>476,183</b>	<b>(5,109)</b>	<b>471,074</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	52,854	4,776	107,120	164,750	(15,644)	149,106	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			149,339	149,339		149,339	12
13	Insurance-Property, Liability and Malpractice			29,920	29,920		29,920	13
14	Other (specify):	52,067	6,108	96,125	154,300	(142,585)	11,715	14
15	<b>TOTAL General Administration</b>	<b>104,921</b>	<b>10,884</b>	<b>382,504</b>	<b>498,309</b>	<b>(158,229)</b>	<b>340,080</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>891,653</b>	<b>244,150</b>	<b>558,493</b>	<b>1,694,296</b>	<b>(167,295)</b>	<b>1,527,001</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			287,800	287,800		287,800	17
18	Interest			341,464	341,464		341,464	18
19	Real Estate Taxes			5,797	5,797		5,797	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			6,726	6,726		6,726	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>641,787</b>	<b>641,787</b>		<b>641,787</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>891,653</b>	<b>244,150</b>	<b>1,200,280</b>	<b>2,336,083</b>	<b>(167,295)</b>	<b>2,168,788</b>	<b>24</b>

Facility Name: Courtyard Estates of Peoria

Report Period Beginning 1/1/2012 Ending: 12/31/2012

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 23.19	1
2	Licensed Practical Nurses	3	17.50	2
3	Certified Nurse Assistants	11	10.11	3
4	Activity Director & Assistants	1	12.37	4
5	Social Service Workers	1	11.00	5
6	Head Cook	1	14.26	6
7	Cook Helpers/Assistants	6	9.53	7
8	Dishwashers			8
9	Maintenance Workers	1	23.53	9
10	Housekeepers	6	10.08	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	2	10.92	14
15	Marketing	1	24.03	15
16	Other	2	10.66	16
17	<b>Total (lines 1 thru 16)</b>	<b>37</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	N/A			\$	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	N/A	\$ 1
2		2
<b>Total</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
See Attached Schedule 4B			

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: Petersen Health Care, Inc. If yes, what is the value of those services? \$ 69,600

(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: Courtyard Estates of Peoria

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VIII. OWNERSHIP COSTS

A. Purchase price of land 470,000 Year land was acquired 2011

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	100		2011	2011	\$ 5,537,053	\$ 221,482	25	\$ 110,741	\$ (110,741)	\$ 166,111	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Sewer Line Repair		2012	4,487	641	7	321	(320)	321	6
7		Condenser Unit		2012	9,580	373	15	319	(54)	319	7
8		Heat Pump		2012	11,411	815	7	815		815	8
9		Electrical Work		2012	10,125	225	15	338	113	338	9
10		Fire Alarm System		2012	2,525	60	7	180	120	180	10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 5,575,181	\$ 223,596		\$ 112,714	\$ (110,882)	\$ 168,084	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	\$ 399,615	\$ 56,846	\$ 38,553	(18,293)	7 yrs.	\$ 57,125	18
19	Vehicles	36,788	7,358	7,358		5 yrs.	11,037	19
20	TOTAL (lines 18 and 19)	\$ 436,403	\$ 64,204	\$ 45,911	(18,293)		\$ 68,162	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: Courtyard Estates of Peoria

Report Period Beginning: 1/1/2012

Ending: 2/31/2012

**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	<b>TOTAL</b>				\$			7

8. Is movable equipment rental included in building rental?  YES  NO

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	1st Mid-Illinois Bank & Trust		X	Mortgage	1/1/11	\$ 5,249,269	\$ 5,157,664	3/4/16	5.0000	\$ 306,115	1
2	Ford Credit		X	Van	7/14/11	36,505	23,835	6/30/16	6.2900	1,794	2
3					/ /			/ /			3
	<b>Working Capital</b>										
4	1st Mid-Illinois Bank & Trust		X	Line of Credit	/ /	157,471	157,471	/ /		6,884	4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$ 5,443,245	\$ 5,338,970			\$ 314,793	7
	<b>B. Non-Facility Related</b>										
8					/ /			/ /	Amort. Exp.	26,671	8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 5,443,245	\$ 5,338,970			\$ 341,464	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: Courtyard Estates of Peoria

Report Period Beginning: 1/1/2012

Ending:

12/31/2012

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 500	\$ 500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	622,405	622,405	3
4	Supply Inventory (priced : <u>Cost</u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,182	30,182	6
7	Other Prepaid Expenses			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>	\$ 653,087	\$ 653,087	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	470,000	470,000	13
14	Buildings, at Historical Cost	5,537,053	5,537,053	14
15	Leasehold Improvements, at Historical Cost	38,128	38,128	15
16	Equipment, at Historical Cost	436,401	436,401	16
17	Accumulated Depreciation (book methods)	(381,193)	(236,246)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(236,246)	20
21	Restricted Funds			21
22	Other Long-Term Assets ( <b>Loan Costs</b> )	46,456	46,456	22
23	Other(specify): <b>Non-Care Asset</b>	61,800	61,800	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 6,208,645	\$ 6,117,346	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,861,732	\$ 6,770,433	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,695,181	\$ 1,695,181	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	157,471	157,471	29
30	Accrued Salaries Payable	36,085	36,085	30
31	Accrued Taxes Payable	66,600	66,600	31
32	Accrued Interest Payable	16,756	16,756	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<b>Payroll Withholdings</b>	33,632	33,632	35
36	<b>Accred Management Fees</b>	232,724	232,724	36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 2,238,449	\$ 2,238,449	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	23,835	23,835	38
39	Mortgage Payable	5,157,664	5,157,664	39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42	<b>Security Deposit and A/P-Other</b>	22,710	22,710	42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 5,204,209	\$ 5,204,209	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 7,442,658	\$ 7,442,658	45
46	<b>TOTAL EQUITY</b>	\$ (580,926)	\$ (672,225)	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 6,861,732	\$ 6,770,433	47

\*(See instructions.)

Facility Name: Courtyard Estates of Peoria

Report Period Beginning: 1/1/2012

Ending:

12/31/2012

**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	\$ 2,531,309	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 2,531,309</b>	<b>3</b>
<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	3,855	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 3,855</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	Cable Television Revenue	45	15
16	Miscellaneous Income & Barber/Beauty Revenue	13,605	16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 13,650</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 2,548,814</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	719,804	19
20	Health Care/ Personal Care	476,183	20
21	General Administration	498,309	21
<b>B. Capital Expense</b>			
22	Ownership	641,787	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>\$ 2,336,083</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 212,731</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>\$ 212,731</b>	<b>31</b>







