

		FOR BHF USE			

LL2

Supportive Living Facility

**2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2015)**

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. Facility ID Number: 1000036</p> <p>Facility Name: <u>Coles Supportive Living</u></p> <p>Address: <u>7419 South Exchange</u> <u>Chicago</u> <u>60649</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: (<u>773</u>) <u>721-6600</u> Fax # (<u>773</u>) <u>721-6602</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>5/19/2004</u></p> <p>Type of Ownership:</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>IRS Exemption Code _____</td> <td><input 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 checked="" 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>Andrew B. Cutler</u> Telephone Number: <u>(847) 374-0400</u> Email Address: _____</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 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 _____		<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>01/01/2015</u> to <u>12/31/2015</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;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director</u> (Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u> (Telephone) <u>(847) 374-0400</u> Fax # <u>(847) 374-0420</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>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director</u> (Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u> (Telephone) <u>(847) 374-0400</u> Fax # <u>(847) 374-0420</u>
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Facility Name Coles Supportive LivingReport Period Beginning: 01/01/2015 Ending: 12/31/2015**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	129	Single Unit Apartment	129	47,085	1
2	10	Double Unit Apartment	10	3,650	2
3		Other			3
4	139	TOTALS	139	50,735	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	26,407	1,227		27,634	5
6	Double Unit					6
7	Other					7
8	TOTALS	26,407	1,227		27,634	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 54.47%

D. Indicate the number of paid bed-hold days the SLF had during this year
509 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 37 **(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

ACCURAL MODIFIED CASH* CASH*

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

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

* 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. _____

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. _____

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. _____

Facility Name: Coles Supportive Living

Report Period Beginning:

01/01/2015

Ending: 12/31/2015

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	182,409	192,464	4,521	379,394		379,394	1
2	Housekeeping, Laundry and Maintenance	126,370	36,475	96,473	259,318	(30,912)	228,406	2
3	Heat and Other Utilities			134,023	134,023		134,023	3
4	Other (specify): Scavenger/Alarm Services			27,315	27,315		27,315	4
5	TOTAL General Services	308,779	228,939	262,332	800,050	(30,912)	769,138	5
B. Health Care and Programs								
6	Health Care/ Personal Care	453,487			453,487		453,487	6
7	Activities and Social Services	37,034	13,932		50,966		50,966	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	490,521	13,932		504,453		504,453	9
C. General Administration								
10	Administrative and Clerical	188,069	9,135	382,681	579,885	(56,723)	523,162	10
11	Marketing Materials, Promotions and Advertising			468	468		468	11
12	Employee Benefits and Payroll Taxes			240,346	240,346	47,153	287,499	12
13	Insurance-Property, Liability and Malpractice			86,134	86,134	98	86,232	13
14	Other (specify):							14
15	TOTAL General Administration	188,069	9,135	709,629	906,833	(9,472)	897,361	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	987,369	252,006	971,961	2,211,336	(40,384)	2,170,952	16
Capital Expenses								
D. Ownership								
17	Depreciation			32,859	32,859	220,508	253,367	17
18	Interest			157,807	157,807	67,094	224,901	18
19	Real Estate Taxes			108,521	108,521		108,521	19
20	Rent -- Facility and Grounds			540,000	540,000	(535,807)	4,193	20
21	Rent -- Equipment			6,345	6,345	391	6,736	21
22	Other (specify):							22
23	TOTAL Ownership			845,532	845,532	(247,814)	597,718	23
24	GRAND TOTAL (Sum of lines 16 and 23)	987,369	252,006	1,817,493	3,056,868	(288,198)	2,768,670	24

Detail lines 29 and 35 of Page 5 starting in C12.

DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.
 The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS

Page 3A

COLES SUPPORTIVE LIVING

Report Period Beginning: 1/1/2013
 Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. IV Line Reference	
1	Non-Straight Line Depreciation	\$ (29,113)	17	1
2				2
3	Cable TV	(22,907)	10	3
4	Bank Charges	(7,692)	10	4
5	Bad Debts	(66,027)	10	5
6	Non-Allowable Interest Expense	(157,807)	18	6
7	Penalties and Fines	(1,656)	10	7
8	Non-Allowable R&M Expense - Stujac	(31,248)	2	8
9	Misc. Income	(301)	10	9
10	Franchise Tax	(250)	10	10
11	BUILDING COMPANY:			11
12	Rent Expense	(540,000)	20	12
13	Interest Expense	234,239	18	13
14	Accounting Fees	27,146	10	14
15	Depreciation	249,282	17	15
16	Interest Income	(9,338)	18	16
17				17
18				18
19				19
20				20
21	MANAGEMENT OFFICE ALLOCATION:			21
22	Management Office Allocation	(20,173)	10	22
23	General and Administrative Expenses	18,700	10	23
24	Employee Benefits	3,963	12	24
25				25
26				26
27				27
28				28
29	APEX HEALTHCARE ALLOCATION:			29
30	Administrative Salaries	133,980	10	30
31	Emp. Ben. - Gen. Admin.	43,190	12	31
32	General and Administrative Expenses	17,444	10	32
33	Seminars	41	10	33
34	Auto & Travel	8,914	10	34
35	Insurance	98	13	35
36	Depreciation	339	17	36
37	Rent	4,193	20	37
38	Equipment Rental	391	21	38
39	Building Supplies	336	02	39
40	Management Office Allocation	(143,942)	10	40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51	Total	(288,198)		51

Facility Name: Coles Supportive Living

Report Period Beginning 01/01/2015 Ending: 12/31/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 25.77	1
2	Licensed Practical Nurses	5	21.55	2
3	Certified Nurse Assistants	10	10.45	3
4	Activity Director & Assistants	2	11.48	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	8	10.70	7
8	Dishwashers			8
9	Maintenance Workers	1	13.85	9
10	Housekeepers	4	10.82	10
11	Laundry			11
12	Managers			12
13	Other Administrative	2	26.64	13
14	Clerical	3	11.23	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	36	\$ 13.20	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	Aaron Mann Administrative	Relative	8	\$ 48,151	1
2					2
3					3
4					4
5					5
Total				\$ 48151	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>
See Attached	

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
See Attached		
Coles 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: Coles Supportive Living

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VIII. OWNERSHIP COSTS

A. Purchase price of land 214,665 Year land was acquired 2004

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	139		2004	2004	\$ 6,855,929	\$ 249,282	35	\$ 195,884	\$ (53,398)	\$ 2,556,853	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Leashold Improvements			2005	39,296		20	1,965	1,965	21,264	6
7	Leashold Improvements			2006	76,634		20	3,832	3,832	32,813	7
8	Leashold Improvements			2007	262,435		20	13,122	13,122	95,523	8
9	Leashold Improvements			2008	266,438		20	13,322	13,322	86,378	9
10	Leashold Improvements			2009	32,807		20	1,640	1,640	11,112	10
11	Leashold Improvements			2010	40,068		20	2,003	2,003	10,823	11
12	Leashold Improvements			2011	3,840		20	192	192	784	12
13	Leashold Improvements			2012	3,836		20	192	192	432	13
14	Leashold Improvements			2014	4,015		20	201	201	225	14
15	Allocated APEX					339		339			15
16	Book Depreciation					32,859			(32,859)		16
17	TOTAL (lines 1 thru 16)				\$ 7,585,298	\$ 282,480		\$ 232,691	\$ (49,789)	\$ 2,816,206	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	\$ 332,860	\$	\$ 20,676	20,676	10	\$ 291,614	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 332,860	\$	\$ 20,676	20,676		\$ 291,614	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: Coles Supportive Living

Report Period Beginning: 01/01/2015

Ending: 2/31/2015

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	Alloc. Management Co.		/ /	391			5
6			/ /				6
7	TOTAL			\$ 391			7

8. Is movable equipment rental included in building rental?

YES NO

9. Rental amount for movable equipment \$ 6,736

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	Private Bank		X	Mortgage	/ /	\$	4,220,255	/ /		\$ 234,239	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	Arlene Ventures, LLC	X		Working Capital	/ /		2,000,000	/ /		5,833	4
5	Venture Fund, LLC	X		Working Capital	/ /		2,427,745	/ /		157,803	5
6	Due to/from Related Parties	X		Working Capital	/ /		773,982	/ /			6
7	TOTAL Facility Related					\$	9,421,982			\$ 397,875	7
	B. Non-Facility Related										
8	Non-Allowable Interest				/ /			/ /		-163,636	8
9	Interest Income/Allocated Interest				/ /			/ /		-9,338	9
10	TOTALS (lines 7, 8 and 9)					\$	9,421,982			\$ 224,901	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: **Coles Supportive Living**Report Period Beginning: **01/01/2015**Ending: **12/31/2015****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2015**

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 216,717	\$ 907,359	1
2	Cash-Patient Deposits	9,611	9,611	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	222,843	222,843	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		413,010	5
6	Prepaid Insurance	81,685 #	81,685	6
7	Other Prepaid Expenses	152	152	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	92	92	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 531,100	\$ 1,634,752	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		214,665	13
14	Buildings, at Historical Cost		6,855,929	14
15	Leasehold Improvements, at Historical Cost	119,595	119,595	15
16	Equipment, at Historical Cost	204,112	348,076	16
17	Accumulated Depreciation (book methods)	(240,030)	(3,261,350)	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):	21,255	828,557	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 104,932	\$ 5,105,472	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 636,032	\$ 6,740,224	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 373,494	\$ 373,494	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	773,982	773,982	29
30	Accrued Salaries Payable	56,274	56,274	30
31	Accrued Taxes Payable	2,632	2,632	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Unclaimed Property Withholding	1,211	1,211	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,207,593	\$ 1,207,593	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	2,427,745	5,355,638	38
39	Mortgage Payable		4,220,255	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)	\$ 2,427,745	\$ 9,575,893	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,635,338	\$ 10,783,486	45
46	TOTAL EQUITY	\$ (2,999,306)	\$ (4,043,262)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 636,032	\$ 6,740,224	47

*(See instructions.)

Coles Supportive Living
Page 6 & 7 Supplemental
1/1/15-12-31/15

Page 6

Description	Amount
Copier	5,448
Postage Meter	897
Allocated Management Co.	391
Total Equipment Rental	6,736

Page 7: Line 9 Other (Specify)

Description	Operating	Consolidated
Wage Assignments	92	92
Total	92	92

Page 7: Line 23 Other (specify)

Description	Operating	Consolidated
Deposits	21,255	21,255
Permanent Mortgage Costs	-	91,212
Amort. Permanent Mortgage Costs	-	(68,888)
N/R TODO Holdings		750,000
Capitalized Environmental Costs		34,978
Total	21,255	828,557

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	\$ 2,944,863	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,944,863	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	630	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 630	14
D. Other Revenue (specify):			
15	Misc. Income	301	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 301	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,945,794	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	800,050	19
20	Health Care/ Personal Care	504,453	20
21	General Administration	906,833	21
B. Capital Expense			
22	Ownership	845,532	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)	\$ 3,056,868	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (111,074)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (111,074)	31