

		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: 1000100</p> <p>Facility Name: <u>Pinnacle Place</u></p> <p>Address: <u>1125 North 5th St</u> <u>Savanna</u> <u>61074</u> Number City Zip Code</p> <p>County: <u>Carroll</u></p> <p>Telephone Number: (<u>815</u>) <u>273-2105</u> Fax # <u>815 778-4503</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>6/30/2008</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" 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 <u>501(c) 3</u></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 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: _____ Telephone Number: (_____) _____ Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" 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 <u>501(c) 3</u>	<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>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>06/30/2015</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) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) _____ Fax # (_____) _____</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) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) _____ Fax # (_____) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) _____ Fax # (_____) _____																												

Facility Name Pinnacle Place

Report Period Beginning: 01/01/2015 Ending: 06/30/2015

III. STATISTICAL DATA

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

Date of change in certified units / /

	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	19	Single Unit Apartment	19	3,439	1
2	2	Double Unit Apartment	2	362	2
3		Other			3
4	21	TOTALS	21	3,801	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	638	2,005		2,643	5
6	Double Unit	181	296		477	6
7	Other					7
8	TOTALS	819	2,301		3,120	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 82.08%

D. Indicate the number of paid bed-hold days the SLF had during this year 18 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 10 (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)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2015 Fiscal Year: 06/30/2015

* 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: Pinnacle Place

Report Period Beginning:

01/01/2015

Ending: 06/30/2015

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	19,705	25,965	413	46,083		46,083	1
2	Housekeeping, Laundry and Maintenance	11,203	4,953	12,921	29,077		29,077	2
3	Heat and Other Utilities			38,108	38,108	(3,117)	34,991	3
4	Other (specify):							4
5	TOTAL General Services	30,908	30,918	51,441	113,267	(3,117)	110,150	5
B. Health Care and Programs								
6	Health Care/ Personal Care	70,633	292		70,924		70,924	6
7	Activities and Social Services							7
8	Other (specify):							8
9	TOTAL Health Care and Programs	70,633	292		70,924		70,924	9
C. General Administration								
10	Administrative and Clerical	30,692	445	5,189	36,326	1,789	38,115	10
11	Marketing Materials, Promotions and Advertising			3,929	3,929		3,929	11
12	Employee Benefits and Payroll Taxes			19,081	19,081	3,433	22,514	12
13	Insurance-Property, Liability and Malpractice			4,840	4,840		4,840	13
14	Other (specify):							14
15	TOTAL General Administration	30,692	445	33,038	64,175	5,222	69,397	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	132,232	31,655	84,479	248,366	2,105	250,471	16
Capital Expenses								
D. Ownership								
17	Depreciation			33,506	33,506		33,506	17
18	Interest			10,645	10,645		10,645	18
19	Real Estate Taxes			4,523	4,523		4,523	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			48,673	48,673		48,673	23
24	GRAND TOTAL (Sum of lines 16 and 23)	132,232	31,655	133,152	297,039	2,105	299,144	24

PINNACLE PLACE
1125 N. 5TH ST.
SAVANNA, IL 61074
FEIN 23-7136038

2015 Cost Report

SCHEDULE OF RECLASSIFICATION
Page3, Schedule IV

Line #	D	C
		<u>\$2,575</u>
3 REMOVE RESIDENT ROOM PORTION OF CABVLE TV		
10 ADJUSTMENT FOR RELATEI	\$1,789	
12 ORGANIZATION COSTS	\$3,433	

Facility Name: Pinnacle Place

Report Period Beginning 01/01/2015 Ending: 06/30/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.24	\$ 21.26	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	4.86	12.44	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1.89	9.91	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers	0.99	10.82	9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.06	15.27	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	9.04	\$ 12.30	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	Winning Wheels	100		\$	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>
Winning Wheels	Prophetstown
STRIVE	Prophetstown
Frontier Hollow	Prophetstown

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
American Health Enterprises	Lyndon	Mgt. Company

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).

PINNACLE PLACE
 1125 N. 5th St.
 Savanna, IL 61074
 FIN: 23-7136038

2015 Cost Report

SCHEDULE OF RELATED ORGANIZATION COSTS

Page 4, Schedule VII, Question C

Page 3 Line #	Related Organization	Nature of Expense	Cost per General Ledger	Cost to Related Organization	Difference: Adjustment for Related Organization Cost
10	American Health Enterprises 501 6th Ave. W., Lyndon, IL 61261	Administrative contract service	31,002		-31,002
10	American Health Enterprises 501 6th Ave. W., Lyndon, IL 61261	Manager salary		28,610	28,610
10	American Health Enterprises 501 6th Ave. W., Lyndon, IL 61261	Home office salaries		3,702	3,702
12	American Health Enterprises 501 6th Ave. W., Lyndon, IL 61261	Employee benefits		3,433	3,433
10	American Health Enterprises 501 6th Ave. W., Lyndon, IL 61261	Home office costs		479	479
	Total Difference: Adjustment for Related Organization Cost				5,222

Facility Name: Pinnacle Place

Report Period Beginning:

01/01/2015

Ending:

06/30/2015

VIII. OWNERSHIP COSTS

A. Purchase price of land 40,000 Year land was acquired 1997

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	21		1997		\$ 1,155,267	\$ 42,010	28	\$ 42,010		\$ 764,297	1
2											2
3											3
4											4
5											5
Improvement Type											
6		BUILDING ADDITION			107,843	2,696	40	2,696		46,058	6
7		BUILDING ADDITION			16,500	600	28	600		10,775	7
8		WATER HEATER			3,357	86	39	86		1,380	8
9		SEAL PARKING LOT			6,240	368	15	416	48	5,687	9
10		CHIMNEY CAPS			984	36	28	36		455	10
11		TUCK POINTING			128,000	4,655	28	4,655		58,376	11
12		REMODEL BATH			24,893	905	28	905		11,277	12
13		ROOF			92,377	3,359	28	3,359		41,290	13
14		CARPET			8,269		7			8,269	14
15		ENTRANCE SIGN			1,621	96	15	108	12	1,094	15
16		SEE PAGE 5 SUPPORT			200,195	11,060		13,762	2,702	125,647	16
17		TOTAL (lines 1 thru 16)			\$ 1,745,546	\$ 65,871		\$ 68,633	\$ 2,762	\$ 1,074,605	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	\$ 130,695	\$ 1,833	\$ 2,141	308	9	\$ 120,189	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 130,695	\$ 1,833	\$ 2,141	308		\$ 120,189	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

STATE OF ILLINOIS

Page 5 Support

Facility Name: Pinnacle Place

Report Period Beginning:

1/1/2015

Ending:

6/30/2015

SCHEDULE OF PAGE 5, SCHEDULE VIII, SECTION B, LINE 16

		3	4	5	6	7	8	9	
		Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
		Constructed		Depreciation	in Years	Depreciation		Depreciation	
1	ASBESTOS REMOVAL	2007	960	57	15	64	7	592	1
2	LOCKS	2008	4,386	259	15	292	33	2,444	2
3	SMOKE DETECTORS	2008	19,522	1,153	15	1,302	149	10,876	3
4	FIRE DOORS	2008	7,843	463	15	523	60	4,370	4
5	FLOORING	2009	700	62	7	100	38	689	5
6	WASHERS AND DRYERS	2007	3,685	0	7	526	526	3,685	6
7	PLASMA TV	2009	1,050	0	3	0	0	1,050	7
8	A/C CONDENSOR	2009	1,020	91	7	146	55	975	8
9	ICE MACHINE	2009	2,295	205	7	328	123	2,193	9
10	WATER HEATER	2009	4,628	413	7	661	248	4,421	10
11	PARKING LOT	1997	31,223	0	15	0	0	31,223	11
12	REFRIGERATOR	2004	2,799		7		0	2,799	12
13	WATER HEATER	2004	4,214		7		0	4,214	13
14	NURSE CALL SYSTEM	2005	24,971	1,249	10	1,249	0	24,971	14
15	ZENITH TV	2005	2,845		7		0	2,845	15
16	SLF ASSESSMENT	2008	9,879	583	15	583	0	5,504	16
17	DELL COMPUTER	2008	728		5		0	728	17
18	FLOORING	2010	940	54	5	54	0	940	18
19	WHIRLPOOL	2010	8,841	789	7	789	0	7,657	19
20	FLOORING	2010	853	49	5	170	121	523	20
21	AWNING	2010	2,030	127	15	135	8	891	21
22	EROSION CONTROL	2010	7,195	498	15	480	(18)	3,159	22
23	FLOORING	2010	1,467	169	5	293	124	1,467	23
24	FLOORING-DINING ROOM AND FRONT ACTIVITY	2013	5,801	828	7	828	0	1,242	24
25	ROOF REPAIRS AROUND ELEVATOR	2013	12,980	865	15	865	0	1,803	25
26	ELEVATOR REPAIRS	2014	11,464	819	7	1,638	819	1,638	26
27	LOCKS AND KEYS	2014	2,633	376	7	376	0	564	27
28	APARTMENT FLOORING	2014	1,622	232	7	232	0	347	28
29	APARTMENT FURNACE	2014	1,422	203	7	203	0	288	29
30	APARTMENT FLOORING	2014	1,379	197	7	197	0	230	30
31	AIR CONDITIONER	2014	1,327	174	7	174	0	174	31
32	ELEVATOR REPAIRS	2014	9,171	655	7	655	0	655	32
33	APARTMENT FLOORING	2015	2,019	144	7	144	0	144	33
34	APARTMENT FLOORING	2015	1,739	104	7	104	0	104	34
35	REPLACED COMPRESSOR	2015	1,584	113	7	226	113	113	35
36	SNOWBLOWER	2015	917	55	7	131	76	55	36
37	PLOW TRUCK ACCESSORIES	2015	2,063	74	7	294	220	74	37
38							0		38
	TOTAL FOR LINE 16 ON PAGE 5		\$ 200,195	\$ 11,060		\$ 13,762	\$ 2,702	\$ 125,647	

Facility Name: Pinnacle Place

Report Period Beginning: 01/01/2015

Ending: 6/30/2015

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	TOTAL			\$			7

8. Is movable equipment rental included in building rental? 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												
A. Directly Facility Related																
Long-Term																
1	Midland States Bank			X	Mortgage		7/27/07	\$ 744,497	\$ 540,248	2/27/28	3.7700	\$ 10,460	1			
2							/ /			/ /			2			
3							/ /			/ /			3			
Working Capital																
4							/ /			/ /			4			
5							/ /			/ /			5			
6							/ /			/ /			6			
7	TOTAL Facility Related							\$ 744,497	\$ 540,248			\$ 10,460	7			
B. Non-Facility Related																
8							/ /			/ /			8			
9							/ /			/ /			9			
10	TOTALS (lines 7, 8 and 9)							\$ 744,497	\$ 540,248			\$ 10,460	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: Pinnacle Place

Report Period Beginning: 01/01/2015

Ending:

06/30/2015

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2015

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (4,608)	\$ (4,608)	1
2	Cash-Patient Deposits	96	96	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	67,468	67,468	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	185	185	6
7	Other Prepaid Expenses	4,599	4,599	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid dues	945	945	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 68,684	\$ 68,684	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000	40,000	13
14	Buildings, at Historical Cost	1,565,621	1,565,621	14
15	Leasehold Improvements, at Historical Cost	48,925	48,925	15
16	Equipment, at Historical Cost	130,695	130,695	16
17	Accumulated Depreciation (book methods)	(1,194,794)	(1,194,794)	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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 590,447	\$ 590,447	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 659,131	\$ 659,131	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 21,000	\$ 21,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,106	2,106	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	9,500	9,500	31
32	Accrued Interest Payable	180	180	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 32,786	\$ 32,786	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	540,248	540,248	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)	\$ 540,248	\$ 540,248	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 573,034	\$ 573,034	45
46	TOTAL EQUITY	\$ 86,097	\$ 86,097	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 659,131	\$ 659,131	47

*(See instructions.)

Facility Name: Pinnacle Place

Report Period Beginning: 01/01/2015

Ending:

06/30/2015

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	\$ 281,470	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 281,470	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services	4,016	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	2,539	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 6,555	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 288,025	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	113,267	19
20	Health Care/ Personal Care	70,924	20
21	General Administration	64,175	21
B. Capital Expense			
22	Ownership	48,673	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)	\$ 297,039	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (9,015)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (9,015)	31