

		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>THE POINTE AT KILPATRICK, LP</u></p> <p>Address: <u>14230 S. KILPATRICK</u> <u>CRESTWOOD</u> <u>60445</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(708) 293-0010</u> Fax # <u>(708) 293-0020</u></p> <p>Federal Employer ID Number: <u>36-4391041</u></p> <p>Date Current Owners were Certified: <u>12/1/03</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>ELIZABETH KOSHY</u> Telephone Number: <u>(847) 583-0100 X124</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 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>01/01/05</u> to <u>12/31/05</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" style="width:100%"> <tr> <td rowspan="2" style="width:20%">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>SHAEL BELLOWS</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>GENERAL PARTNER</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width:20%">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> <td></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) <u>SHAEL BELLOWS</u>			(Title) <u>GENERAL PARTNER</u>		Paid Preparer	(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 THE POINTE AT KILPATRICK, LP

Report Period Beginning: 01/01/05 Ending: 12/31/05

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	44	Single Unit Apartment	44	14,965	1
2	78	Double Unit Apartment	78	28,470	2
3		Other		1,095	3
4	122	TOTALS	122	44,530	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	11,237	3,289		14,526	5
6	Double Unit	15,077	9,744	798	25,619	6
7	Other					7
8	TOTALS	26,314	13,033	798	40,145	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.15%

D. Indicate the number of paid bed-hold days the SLF had during this year 413 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 6 (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: 01/05-12/05 Fiscal Year: 01/05-12/05

* 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: THE POINTE AT KILPATRICK, LP

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	215,561	191,482	2,180	409,223	(78,417)	330,806	1
2	Housekeeping, Laundry and Maintenance	67,379	41,434	438	109,251		109,251	2
3	Heat and Other Utilities			120,483	120,483	(1,134)	119,349	3
4	Other (specify):			9,940	9,940		9,940	4
5	TOTAL General Services	282,940	232,916	133,041	648,897	(79,551)	569,346	5
B. Health Care and Programs								
6	Health Care/ Personal Care	372,705	2,730		375,435		375,435	6
7	Activities and Social Services	46,512	6,665		53,177		53,177	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	419,217	9,395		428,612		428,612	9
C. General Administration								
10	Administrative and Clerical	131,437	23,579	603,487	758,503	(405)	758,098	10
11	Marketing Materials, Promotions and Advertising	93,208	10,525	7,494	111,227		111,227	11
12	Employee Benefits and Payroll Taxes			196,494	196,494		196,494	12
13	Insurance-Property, Liability and Malpractice			111,837	111,837		111,837	13
14	Other (specify):			105,148	105,148	(500)	104,648	14
15	TOTAL General Administration	224,645	34,104	1,024,460	1,283,209	(905)	1,282,304	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	926,802	276,415	1,157,501	2,360,718	(80,456)	2,280,262	16
Capital Expenses								
D. Ownership								
17	Depreciation			642,823	642,823		642,823	17
18	Interest			619,467	619,467		619,467	18
19	Real Estate Taxes			187,074	187,074		187,074	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): MORTGAGE INSURANCE			23,705	23,705		23,705	22
23	TOTAL Ownership			1,473,069	1,473,069		1,473,069	23
24	GRAND TOTAL (Sum of lines 16 and 23)	926,802	276,415	2,630,570	3,833,787	(80,456)	3,753,331	24

Facility Name: THE POINTE AT KILPATRICK, LP

Report Period Beginning 01/01/05 Ending: 12/31/05

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 30.96	1
2	Licensed Practical Nurses	2	22.00	2
3	Certified Nurse Assistants	11	9.92	3
4	Activity Director & Assistants	2	13.07	4
5	Social Service Workers	1	21.44	5
6	Head Cook	2	13.07	6
7	Cook Helpers/Assistants	13	8.15	7
8	Dishwashers			8
9	Maintenance Workers	1	15.22	9
10	Housekeepers	2	8.68	10
11	Laundry			11
12	Managers	1	24.72	12
13	Other Administrative			13
14	Clerical	4	11.41	14
15	Marketing	3	19.68	15
16	Other			16
17	Total (lines 1 thru 16)	43	\$	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	SHAEL BELLOWS GENERAL PARTNER	1%	5	\$	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	1	City	2
SEE ATTACHED LIST OF RELATED ENTITIES			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
NONE					

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: THE POINTE AT KILPATRICK, LP

Report Period Beginning: 01/01/05

Ending: 12/31/05

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			2002		\$ 350,000	\$		\$	\$	\$	1
2	122			2003	12,408,081	451,158	27.5	451,158		921,264	2
3				2003	438,754	39,005	15	29,250	(9,755)	73,125	3
4				2005	300,000	3,183	27.5	3,183		3,183	4
5											5
Improvement Type											
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 13,496,835	\$ 493,346		\$ 483,591	\$ (9,755)	\$ 997,572	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	\$ 645,788	\$ 149,477	\$ 130,217	(19,260)	3-5 YRS	\$ 258,604	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 645,788	\$ 149,477	\$ 130,217	(19,260)		\$ 258,604	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: THE POINTE AT KILPATRICK, LP

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 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	GMAC		X	MORTGAGE	12/1/02	\$ 10,000,000	\$ 9,889,510	1/1/44	0.0620	\$ 614,926	1	
2	LOAN COSTS		X		12/5/03	181,630	172,427	1/1/44		4,541	2	
3					/ /			/ /			3	
	Working Capital											
4					/ /			/ /			4	
5					/ /			/ /			5	
6					/ /			/ /			6	
7	TOTAL Facility Related						\$ 10,181,630	\$ 10,061,937			\$ 619,467	7
	B. Non-Facility Related											
8					/ /			/ /			8	
9					/ /			/ /			9	
10	TOTALS (lines 7, 8 and 9)						\$ 10,181,630	\$ 10,061,937			\$ 619,467	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.

STATE OF ILLINOIS

Page 7

Facility Name: THE POINTE AT KILPATRICK, LP

Report Period Beginning: 01/01/05

Ending:

12/31/05

12/31/05

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,344,549	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	329,897		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,910		6
7	Other Prepaid Expenses	22,414		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): ESCROW DEPOSITS	241,833		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,007,603	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	350,000		13
14	Buildings, at Historical Cost	12,408,081		14
15	Leasehold Improvements, at Historical Cost	738,754		15
16	Equipment, at Historical Cost	645,891		16
17	Accumulated Depreciation (book methods)	(1,422,906)		17
18	Deferred Charges	205,427		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	354,213		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,279,460	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,287,063	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 120,569	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	125,500		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,022		30
31	Accrued Taxes Payable	202,200		31
32	Accrued Interest Payable	51,096		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	MANAGEMENT FEES	397,094		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 916,481	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	9,889,510		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	CONSTRUCTION COSTS PAYABLE	560,269		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 10,449,779	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 11,366,260	\$	45
46	TOTAL EQUITY	\$ 4,920,803	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 16,287,063	\$	47

*(See instructions.)

Facility Name: THE POINTE AT KILPATRICK, LP

Report Period Beginning: 01/01/05

Ending:

12/31/05

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	\$ 3,367,591	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 3,367,591	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
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	3,414	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 3,414	14
D. Other Revenue (specify):			
15	NET VENDING COMMISSIONS	405	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 405	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 3,371,410	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	648,897	19
20	Health Care/ Personal Care	428,612	20
21	General Administration	1,283,209	21
B. Capital Expense			
22	Ownership	1,473,069	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 3,833,787	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (462,377)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (462,377)	31

IV.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		TOTAL
1	DIETARY AND FOOD PURCHASE	
	DIETITIAN - CONSULTANT	750
	REPAIRS AND MAINTENANCE	1,430
2	HOUSEKEEPING, LAUNDRY AND MAINTENANCE	
	OUTSIDE LABOR	438
	LAUNDRY EQPT REPAIRS & MTCE	438
3	HEAT AND OTHER UTILITIES	
	GAS	49,031
	ELECTRICITY	62,563
	WATER	7,755
	CABLE TV	1,134
		120,483
4	OTHER	
	SCAVENGER	3,095
	EXTERMINATING SERVICE	1,982
	FIRE SERVICE	3,919
	SECURITY SERVICE	944
		9,940
6	HEALTH CARE/PERSONAL CARE	
	NURSE CONSULTANT	
		0
7	ACTIVITIES AND SOCIAL SERVICES	
	SOCIAL WORKER	
		0
8	OTHER	
		0
10	ADMINISTRATIVE AND CLERICAL	
	EMPLOYEE WANT ADS	
	PENALTIES	136
	TELEPHONE	14,721
	MANAGEMENT FEES	587,461
	BANK CHARGES	269
	THEFT & DAMAGE LOSS	900
		0
		603,487

LINE	SCHED REF	TOTAL
11	MARKETING MATERIALS, PROMOTIONS & ADV.	
	MARKETING CONSULTANT	
	YELLOW PAGES & NEWSPAPER ADS	7,494
	WEB ADVERTISING	
		7,494
12	EMPLOYEE BENEFITS AND PAYROLL TAXES	
	PAYROLL TAXES	98,629
	WORKERS COMP. INSURANCE	41,386
	HEALTH INSURANCE	50,358
	PENSION PLAN CONTRIBUTIONS	284
	EMPLOYEE BENEFITS - OTHER	5,837
		196,494
13	INSURANCE - PROPERTY, LIABILITY	111,837
14	OTHER (GENERAL ADMINISTRATION)	
	EMPLOYEE WANT ADS	12,667
	POLITICAL CONTRIBUTIONS	500
	CONTRIBUTIONS	140
	DATA PROCESSING	15,680
	DUES AND SUBSCRIPTIONS	3,405
	EDUCATION AND SEMINARS	3,539
	LICENSES AND PERMITS	5,378
	ACCOUNTING FEES	10,921
	LEGAL FEES	9,957
	OTHER PROFESSIONAL FEES	38,263
	TRANSPORTATION STAFF	4,698
		105,148
17	DEPRECIATION	642,823
18	INTEREST	619,467
19	REAL ESTATE TAXES	187,074
20	RENT -- FACILITY AND GROUNDS	0
21	RENT - EQUIPMENT	0
22	OTHER (OWNERSHIP)	
	MORTGAGE INSURANCE	23,705
		23,705

GRAND TOTAL COLUMN 3 OTHER

2,630,570

IV.COST CENTER EXPENSES PAGE 3 - COLUMN 5 (RECLASSIFICATIONS AND ADJUSTMENTS)

LINE			TOTAL
	GENERAL EXPENSES		
1	FOOD STAMP REVENUE	(78,417)	
3	CABLE TV - RESIDENT ROOMS	(1,134)	
			(79,551)
	HEALTH CARE AND PROGRAMS		
		0	
		0	0
	GENERAL ADMINISTRATION		
10	BANK CHARGES	(269)	
10	PENALTIES	(136)	
14	POLITICAL CONTRIBUTIONS	(500)	
		0	(905)
	OWNERSHIP		
17	STRAIGHTLINE DEPRECIATION ADJ.		
18	INTEREST INCOME		
		0	0