

		FOR BHF USE			

LL2

Supportive Living Facility

**2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2006)**

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</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: _____ Telephone Number: (_____) _____</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>01/01/06</u> to <u>12/31/06</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">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) (_____) _____</td> <td>Fax # (_____) _____</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) (_____) _____	Fax # (_____) _____
<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 _____																																									
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) (_____) _____	Fax # (_____) _____																																								

Facility Name THE POINTE AT KILPATRICK

Report Period Beginning: 01/01/06 Ending: 12/31/06

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	16,060	1
2	78	Double Unit Apartment	78	28,470	2
3		Other			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	8,418	3,843	472	12,733	5
6	Double Unit	15,522	9,108	1,271	25,901	6
7	Other	93	884		977	7
8	TOTALS	24,033	13,835	1,743	39,611	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.95%

D. Indicate the number of paid bed-hold days the SLF had during this year 449 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)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 01/06-12/06 Fiscal Year: 01/06/12/06

* 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

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	216,329	189,595	1,323	407,247	(56,788)	350,459	1
2	Housekeeping, Laundry and Maintenance	65,488	52,040	1,067	118,595		118,595	2
3	Heat and Other Utilities			114,934	114,934	(1,161)	113,773	3
4	Other (specify):			9,576	9,576		9,576	4
5	TOTAL General Services	281,817	241,635	126,900	650,352	(57,949)	592,403	5
B. Health Care and Programs								
6	Health Care/ Personal Care	404,460	2,624		407,084		407,084	6
7	Activities and Social Services	2,964	3,535		6,499		6,499	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	407,424	6,159		413,583		413,583	9
C. General Administration								
10	Administrative and Clerical	229,726	18,394	898,665	1,146,785	(3,002)	1,143,783	10
11	Marketing Materials, Promotions and Advertising			18,584	18,584		18,584	11
12	Employee Benefits and Payroll Taxes			200,558	200,558		200,558	12
13	Insurance-Property, Liability and Malpractice			144,326	144,326		144,326	13
14	Other (specify):			113,914	113,914	(10,377)	103,537	14
15	TOTAL General Administration	229,726	18,394	1,376,047	1,624,167	(13,379)	1,610,788	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	918,967	266,188	1,502,947	2,688,102	(71,328)	2,616,774	16
Capital Expenses								
D. Ownership								
17	Depreciation			595,712	595,712		595,712	17
18	Interest			615,503	615,503	(24,433)	591,070	18
19	Real Estate Taxes			192,684	192,684		192,684	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			7,273	7,273		7,273	21
22	Other (specify): MORTGAGE INSURANCE			48,859	48,859		48,859	22
23	TOTAL Ownership			1,460,031	1,460,031	(24,433)	1,435,598	23
24	GRAND TOTAL (Sum of lines 16 and 23)	918,967	266,188	2,962,978	4,148,133	(95,761)	4,052,372	24

Facility Name: THE POINTE AT KILPATRICK

Report Period Beginning 01/01/06 Ending: 12/31/06

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 33.14	1
2	Licensed Practical Nurses	1	21.96	2
3	Certified Nurse Assistants	10	10.12	3
4	Activity Director & Assistants	2	13.03	4
5	Social Service Workers			5
6	Head Cook	4	14.56	6
7	Cook Helpers/Assistants	11	8.46	7
8	Dishwashers			8
9	Maintenance Workers	1	17.13	9
10	Housekeepers	4	8.73	10
11	Laundry			11
12	Managers	1	25.06	12
13	Other Administrative			13
14	Clerical	3	10.70	14
15	Marketing	2	18.16	15
16	Other			16
17	Total (lines 1 thru 16)	40	\$	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	0.01%	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

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. OWNERSHIP COSTS

A. Purchase price of land 350,000 Year land was acquired 2002

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	122			2003	\$ 12,408,081	\$ 451,158	27.5	\$ 451,158	\$	\$ 1,372,422	1
2				2003	438,754	35,100	15	29,250	(5,850)	90,188	2
3				2005	300,000	10,908	27.5	10,908		14,091	3
4											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)				\$ 13,146,835	\$ 497,166		\$ 491,316	\$ (5,850)	\$ 1,476,701	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	\$ 644,266	\$ 98,546	\$ 69,787	(28,759)	3-10 YRS	\$ 207,307	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 644,266	\$ 98,546	\$ 69,787	(28,759)		\$ 207,307	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

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Amount of Note	Balance				
			YES	NO		Date of Note	Original		Maturity Date			
		A. Directly Facility Related Long-Term										
1		GMAC		X	MORTGAGE	12/1/02	\$ 10,000,000	\$ 9,823,749	1/1/44	0.0620	\$ 610,962	1
2		LOAN COSTS		X		12/5/03	181,630	167,886	1/1/44		4,541	2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 10,181,630	\$ 9,991,635			\$ 615,503	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 10,181,630	\$ 9,991,635			\$ 615,503	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: THE POINTE AT KILPATRICK

Report Period Beginning: 01/01/06

Ending:

12/31/06

12/31/06

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,340,220	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	485,127		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	138,359		6
7	Other Prepaid Expenses	18,652		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): ESCROW DEPOSITS	347,785		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,330,143	\$	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	13,146,835		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	655,104		16
17	Accumulated Depreciation (book methods)	(2,018,618)		17
18	Deferred Charges	200,886		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	425,220		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,759,427	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,089,570	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 114,900	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	154,595		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,656		30
31	Accrued Taxes Payable	208,525		31
32	Accrued Interest Payable	50,756		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	MANAGEMENT FEES	445,446		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 996,878	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	9,823,749		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)	\$ 9,823,749	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,820,627	\$	45
46	TOTAL EQUITY	\$ 4,268,943	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 15,089,570	\$	47

*(See instructions.)

Facility Name: THE POINTE AT KILPATRICK

Report Period Beginning: 01/01/06

Ending:

12/31/06

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	\$ 3,535,869	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 3,535,869	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	24,433	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 24,433	14
D. Other Revenue (specify):			
15	NET VENDING COMMISSIONS	278	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 278	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 3,560,580	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	650,352	19
20	Health Care/ Personal Care	413,583	20
21	General Administration	1,624,167	21
B. Capital Expense			
22	Ownership	1,460,031	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)	\$ 4,148,133	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (587,553)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (587,553)	31

IV.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		TOTAL
1	DIETARY AND FOOD PURCHASE	
	DIETITIAN - CONSULTANT	998 1,323
	REPAIRS AND MAINTENANCE	325
2	HOUSEKEEPING, LAUNDRY AND MAINTENANCE	
	OUTSIDE LABOR	1,067
	LAUNDRY EQPT REPAIRS & MTCE	1,067
3	HEAT AND OTHER UTILITIES	
	GAS	49,200
	ELECTRICITY	56,869
	WATER	7,704
	CABLE TV	1,161
		114,934
4	OTHER	
	SCAVENGER	3,860
	EXTERMINATING SERVICE	1,900
	FIRE SERVICE	2,533
	SECURITY SERVICE	1,283
		9,576
6	HEALTH CARE/PERSONAL CARE	
	NURSE CONSULTANT	
		0
7	ACTIVITIES AND SOCIAL SERVICES	
	SOCIAL WORKER	
		0
8	OTHER	
		0
10	ADMINISTRATIVE AND CLERICAL	
	PENALTIES	45
	TELEPHONE	21,183
	MANAGEMENT FEES	874,480
	BANK CHARGES	2,957
	THEFT & DAMAGE LOSS	
		0
		898,665

LINE	SCHED REF	TOTAL
11	MARKETING MATERIALS, PROMOTIONS & ADV.	
	MARKETING CONSULTANT	
	YELLOW PAGES & NEWSPAPER ADS	18,584
	WEB ADVERTISING	
		18,584
12	EMPLOYEE BENEFITS AND PAYROLL TAXES	
	PAYROLL TAXES	110,936
	WORKERS COMP. INSURANCE	34,538
	HEALTH INSURANCE	47,019
	EMPLOYEE PHYSICAL EXAMS	261
	PENSION PLAN CONTRIBUTIONS	1,126
	EMPLOYEE BENEFITS - OTHER	6,678
		200,558
13	INSURANCE - PROPERTY, LIABILITY	144,326
		144,326
14	OTHER (GENERAL ADMINISTRATION)	
	EMPLOYEE WANT ADS	3,329
	POLITICAL CONTRIBUTIONS	
	CONTRIBUTIONS	310
	DATA PROCESSING	11,723
	DUES AND SUBSCRIPTIONS	4,388
	EDUCATION AND SEMINARS	6,030
	EMPLOYEE BACKGROUND CHECKS	2,078
	LICENSES AND PERMITS	3,881
	ACCOUNTING FEES	10,678
	LEGAL FEES	18,723
	OTHER PROFESSIONAL FEES	38,996
	BAD DEBTS	10,377
	TRANSPORTATION STAFF	3,401
		113,914
17	DEPRECIATION	595,712
		595,712
18	INTEREST	615,503
		615,503
19	REAL ESTATE TAXES	192,684
		192,684
20	RENT -- FACILITY AND GROUNDS	
		0
21	RENT - EQUIPMENT	7,273
		7,273
22	OTHER (OWNERSHIP)	
	MORTGAGE INSURANCE	48,859
		48,859

GRAND TOTAL COLUMN 3 OTHER

2,962,978

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

LINE		TOTAL
	GENERAL EXPENSES	
1	FOOD STAMP REVENUE	(56,788)
3	CABLE TV - RESIDENT ROOMS	(1,161)
		(57,949)
	HEALTH CARE AND PROGRAMS	
		0
	GENERAL ADMINISTRATION	
10	BANK CHARGES	(2,957)
10	PENALTIES	(45)
14	POLITICAL CONTRIBUTIONS	
14	BAD DEBTS	(10,377)
		0
		(13,379)
	OWNERSHIP	
17	STRAIGHTLINE DEPRECIATION ADJ.	
18	INTEREST INCOME	(24,433)
		0
		(24,433)
	GRAND TOTAL - COLMN 5	(95,761)