

		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>Shabbona Supportive Living Facility</u></p> <p>Address: <u>7434 Skokie Blvd</u> <u>Skokie</u> <u>60077</u> <small>Number City Zip Code</small></p> <p>County: <u>Dekalb</u></p> <p>Telephone Number: (<u>847</u>) <u>982-2300</u> Fax # (<u>847</u>) <u>982-2304</u></p> <p>Federal Employer ID Number: <u>20-4590974</u></p> <p>Date Current Owners were Certified: <u>3/30/06</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input 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>Charles J. Fischer</u> Telephone Number: (<u>312</u>) <u>634-4580</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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>3/30/06</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"> <tr> <td rowspan="2" style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>See Accountants' Compilation Report</u></td> </tr> <tr> <td>(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 384-6000</u> Fax <u>(312) 634-5518</u></td> </tr> <tr> <td></td> <td>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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>See Accountants' Compilation Report</u>	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax <u>(312) 634-5518</u>		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
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Facility Name Shabbona Supportive Living Facility

Report Period Beginning: 3/30/06 Ending: 12/31/06

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	29	Single Unit Apartment	29	10,585	1
2	7	Double Unit Apartment	7	2,555	2
3		Other			3
4	36	TOTALS	36	13,140	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	249	1,331		1,580	5
6	Double Unit	98			98	6
7	Other					7
8	TOTALS	347	1,331		1,678	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 12.77%

D. Indicate the number of paid bed-hold days the SLF had during this year
N/A Also, indicate the number of unpaid bed-hold days the SLF had during this year. N/A (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: 12/31/06 Fiscal Year: 12/31/06

* 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? N/A

If no, explain. N/A

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. N/A

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. N/A

Facility Name: Shabbona Supportive Living Facility

Report Period Beginning:

3/30/06

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	44,732	23,813	925	69,470		69,470	1
2	Housekeeping, Laundry and Maintenance	27,635	23,152		50,787		50,787	2
3	Heat and Other Utilities			26,932	26,932		26,932	3
4	Other (specify):							4
5	TOTAL General Services	72,367	46,965	27,857	147,189		147,189	5
B. Health Care and Programs								
6	Health Care/ Personal Care	107,581	668		108,249		108,249	6
7	Activities and Social Services	35,037	1,566		36,603		36,603	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	142,618	2,234		144,852		144,852	9
C. General Administration								
10	Administrative and Clerical	11,965		44,665	56,630	1,671	58,301	10
11	Marketing Materials, Promotions and Advertising			12,662	12,662	(12,662)		11
12	Employee Benefits and Payroll Taxes			29,579	29,579		29,579	12
13	Insurance-Property, Liability and Malpractice			32,089	32,089		32,089	13
14	Other (specify):							14
15	TOTAL General Administration	11,965		118,995	130,960	(10,991)	119,969	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	226,950	49,199	146,852	423,001	(10,991)	412,010	16
Capital Expenses								
D. Ownership								
17	Depreciation			1,575	1,575	79,161	80,736	17
18	Interest			15,973	15,973	117,457	133,430	18
19	Real Estate Taxes			22,500	22,500		22,500	19
20	Rent -- Facility and Grounds			117,000	117,000	(117,000)		20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			157,048	157,048	79,618	236,666	23
24	GRAND TOTAL (Sum of lines 16 and 23)	226,950	49,199	303,900	580,049	68,627	648,676	24

Facility Name: Shabbona Supportive Living Facility

Report Period Beginning 3/30/06 Ending: 12/31/06

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.33	\$ 24.68	1
2	Licensed Practical Nurses	1.00	23.70	2
3	Certified Nurse Assistants	5.00	10.94	3
4	Activity Director & Assistants	1.00	10.93	4
5	Social Service Workers	1.00	20.06	5
6	Head Cook	1.00	10.03	6
7	Cook Helpers/Assistants	2.30	8.52	7
8	Dishwashers			8
9	Maintenance Workers	1.00	13.29	9
10	Housekeepers	1.50	7.89	10
11	Laundry	1.20	7.00	11
12	Managers			12
13	Other Administrative			13
14	Clerical	1.00	9.98	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	16	\$ 12.26	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	Albert Milstein	45%		\$	1
2	Sheldon Wolfe	43%	0.5		2
3	Mo Herman	10%	0.5		3
4	Jeremy Amster	2%			4
5					5
Total				\$ None	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 schedule 4A	

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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).

Shabbona SLF

12/31/2006

Related Organizations

Related Nursing Homes

City

In State:

Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis

Out of State:

St. Elizabeth Healthcare Center	Florissant, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO
Rancho Manor Healthcare and Rehab	Florissant, MO

Other Related Business Entities

S.W. Management Co.	Skokie	Bookkeeping/Management Company
S & E Medical Supply Co.	Skokie	Medical Supplies
*SFO Associates	Skokie	Finance Company
**Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center and Oregon Healthcare Center.

**Pages 6 and 8 are not required for this entity since there was no payment from the nursing home to the related entity.

Facility Name: Shabbona Supportive Living Facility

Report Period Beginning:

3/30/06

Ending:

12/31/06

VIII. OWNERSHIP COSTS

A. Purchase price of land 33,632 Year land was acquired 2006

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	36		2006	2006	\$ 2,590,866	\$ 66,748	27.50	\$ 66,748	\$	\$ 66,748	1
2											2
3											3
4											4
5											5
Improvement Type											
6							5				6
7							5				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)				\$ 2,590,866	\$ 66,748		\$ 66,748	\$	\$ 66,748	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	\$ 86,722	\$ 13,988	\$ 13,988	\$	5	\$ 13,988	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 86,722	\$ 13,988	\$ 13,988	\$		\$ 13,988	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: Shabbona Supportive Living Facility

Report Period Beginning: 3/30/06

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	N/A		/ /	\$			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 \$ N/A

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	MB Financial Bank		X	Mortgage	7/15/04	\$ 1,961,867	\$ 1,961,867	1/15/07	8.2500	\$ 117,457	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	MB Financial Bank	X		Working Capital	6/30/06	500,000	500,000	Demand	8.2500	15,973	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 2,461,867	\$ 2,461,867			\$ 133,430	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 2,461,867	\$ 2,461,867			\$ 133,430	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: **Shabbona Supportive Living Facility**Report Period Beginning: **3/30/06**

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	\$ 35,374	\$ 35,800	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	33,283	33,283	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,557	9,557	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	707,478		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 785,692	\$ 78,640	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		2,590,866	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	10,497	86,722	16
17	Accumulated Depreciation (book methods)	(1,575)	(80,736)	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)	\$ 8,922	\$ 2,596,852	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 794,614	\$ 2,675,492	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,691	\$ 6,691	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	500,000	500,000	29
30	Accrued Salaries Payable	15,261	15,261	30
31	Accrued Taxes Payable	7,138	7,138	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Due to related parties	665,472	665,472	35
36	Misc. Current Liabilities	24,527	24,527	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,219,089	\$ 1,219,089	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		1,961,867	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)	\$	\$ 1,961,867	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,219,089	\$ 3,180,956	45
46	TOTAL EQUITY	\$ (424,475)	\$ (505,464)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 794,614	\$ 2,675,492	47

*(See instructions.)

Shabbona Supportive Living Facility
12/31/2006
Schedule 7A

XL. Line 35

<u>Description</u>	<u>Amount</u>	<u>Consolidated</u>
Due to Shabbona Healthcare	410472	410472
Due to from partners	255000	255000
	<u>665472</u>	<u>665472</u>

XL. Line 36

<u>Description</u>	<u>Amount</u>
Insurance Premium Payable	3234
FiCA Withholding	993
Patient Fund Liability	20300
	<u>24527</u>

Facility Name: Shabbona Supportive Living Facility

Report Period Beginning: 3/30/06

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	\$ 155,574	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 155,574	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		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)	\$ 155,574	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	147,189	19
20	Health Care/ Personal Care	144,852	20
21	General Administration	130,960	21
B. Capital Expense			
22	Ownership	157,048	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify): Rounding		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 580,049	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (424,475)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (424,475)	31