

		FOR BHF USE			

LL2

**Supportive Living Facility**  
**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE & FAMILY SERVICES**  
**COST REPORT FOR**  
**SUPPORTIVE LIVING FACILITIES**  
**(FISCAL YEAR 2007)**

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><b>I.</b></p> <p>Facility Name: <u>THE POINTE AT KILPATRICK</u></p> <p>Address: <u>14230 S. KILPATRICK</u> <u>CRESTWOOD</u> <u>60445</u>          Number City Zip Code</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 border="0"> <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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/07</u> to <u>12/31/07</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">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 &amp; 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																																								
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	(Telephone) ( _____ ) _____	Fax # ( _____ ) _____																																								

Facility Name THE POINTE AT KILPATRICK

Report Period Beginning: 01/01/07 Ending: 12/31/07

**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	6,904	6,209	359	13,472	5
6	Double Unit	15,444	8,533	1,318	25,295	6
7	Other	290	779		1,069	7
8	TOTALS	22,638	15,521	1,677	39,836	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 89.46%

D. Indicate the number of paid bed-hold days the SLF had during this year 454 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)

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**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 01/07-12/07 Fiscal Year: 01/07-12/07

\* 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:

01/01/07

Ending:

12/31/07

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	209,575	195,726	2,352	407,653	(44,069)	363,584	1
2	Housekeeping, Laundry and Maintenance	70,600	30,354	18,955	119,909		119,909	2
3	Heat and Other Utilities			133,498	133,498	(1,119)	132,379	3
4	Other (specify):			9,123	9,123		9,123	4
5	<b>TOTAL General Services</b>	<b>280,175</b>	<b>226,080</b>	<b>163,928</b>	<b>670,183</b>	<b>(45,188)</b>	<b>624,995</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	393,764	4,403		398,167		398,167	6
7	Activities and Social Services		3,374		3,374		3,374	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>393,764</b>	<b>7,777</b>		<b>401,541</b>		<b>401,541</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	232,822	9,294	698,995	941,111	(4,013)	937,098	10
11	Marketing Materials, Promotions and Advertising			15,604	15,604		15,604	11
12	Employee Benefits and Payroll Taxes			191,033	191,033		191,033	12
13	Insurance-Property, Liability and Malpractice			112,009	112,009		112,009	13
14	Other (specify):			123,861	123,861	(20,084)	103,777	14
15	<b>TOTAL General Administration</b>	<b>232,822</b>	<b>9,294</b>	<b>1,141,502</b>	<b>1,383,618</b>	<b>(24,097)</b>	<b>1,359,521</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>906,761</b>	<b>243,151</b>	<b>1,305,430</b>	<b>2,455,342</b>	<b>(69,285)</b>	<b>2,386,057</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			579,707	579,707	(18,351)	561,356	17
18	Interest			611,286	611,286	(29,692)	581,594	18
19	Real Estate Taxes			203,424	203,424		203,424	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			8,350	8,350		8,350	21
22	Other (specify):			48,901	48,901		48,901	22
23	<b>TOTAL Ownership</b>			<b>1,451,668</b>	<b>1,451,668</b>	<b>(48,043)</b>	<b>1,403,625</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>906,761</b>	<b>243,151</b>	<b>2,757,098</b>	<b>3,907,010</b>	<b>(117,328)</b>	<b>3,789,682</b>	<b>24</b>

Facility Name: THE POINTE AT KILPATRICK

Report Period Beginning 01/01/07 Ending: 12/31/07

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 33.63	1
2	Licensed Practical Nurses	1	21.97	2
3	Certified Nurse Assistants	11	10.37	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	3	11.85	6
7	Cook Helpers/Assistants	6	8.49	7
8	Dishwashers			8
9	Maintenance Workers	1	17.77	9
10	Housekeepers	2	8.39	10
11	Laundry			11
12	Managers	1	25.87	12
13	Other Administrative			13
14	Clerical	3	10.68	14
15	Marketing	2	18.79	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>31</b>	<b>\$</b>	<b>17</b>

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	\$ 0	1
2					2
3					3
4					4
5					5
<b>Total</b>				<b>\$</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$ 3</b>

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: 01/01/07

Ending: 12/31/07

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	122			2003	\$ 12,408,081	\$ 451,203	27.5	\$ 451,203	\$	\$ 1,823,625	1
2				2003	438,754	31,653	15	29,251	(2,402)	119,439	2
3				2005	300,000	10,909	27.5	10,909		25,000	3
4											4
5											5
<b>Improvement Type</b>											
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	\$ 493,765		\$ 491,363	\$ (2,402)	\$ 1,968,064	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	\$ 703,129	\$ 85,942	\$ 69,993	(15,949)	3-10 YRS	\$ 255,627	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 703,129	\$ 85,942	\$ 69,993	(15,949)		\$ 255,627	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: 01/01/07

Ending: 12/31/07

**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	<b>TOTAL</b>				\$			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			
		<b>A. Directly Facility Related Long-Term</b>										
1		GMAC		X	MORTGAGE	12/1/02	\$ 10,000,000	\$	1/1/44	0.0620	\$ 606,745	1
2		LOAN COSTS		X		12/5/03	181,630		1/1/44		4,541	2
3						/ /			/ /			3
		<b>Working Capital</b>										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		<b>TOTAL Facility Related</b>					\$ 10,181,630	\$			\$ 611,286	7
		<b>B. Non-Facility Related</b>										
8						/ /			/ /			8
9						/ /			/ /			9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 10,181,630	\$			\$ 611,286	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: 01/01/07

Ending:

12/31/07

12/31/07

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,806,956	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	382,660		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	120,301		6
7	Other Prepaid Expenses	16,458		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>ESCROW DEPOSITS</b>	645,397		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,971,772	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	350,000		13
14	Buildings, at Historical Cost	12,846,835		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	703,131		16
17	Accumulated Depreciation (book methods)	(2,598,325)		17
18	Deferred Charges	496,345		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 11,797,986	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 14,769,758	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 168,162	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	200,855		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,238		30
31	Accrued Taxes Payable	209,542		31
32	Accrued Interest Payable	50,395		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<b>MANAGEMENT FEES</b>	405,256		35
36				36
37	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 36)	\$ 1,060,448	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	9,753,793		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities</b> (sum of lines 38 thru 43)	\$ 9,753,793	\$	44
45	<b>TOTAL LIABILITIES</b> (sum of lines 37 and 44)	\$ 10,814,241	\$	45
46	<b>TOTAL EQUITY</b>	\$ 3,955,517	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 45 and 46)	\$ 14,769,758	\$	47

\*(See instructions.)

Facility Name: THE POINTE AT KILPATRICK

Report Period Beginning: 01/01/07

Ending:

12/31/07

**XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)**

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 3,653,732	1
2	Discounts and Allowances		2
<b>SUBTOTAL Resident Care</b>			
3	(line 1 minus line 2)	\$ 3,653,732	3
<b>B. Other Operating Revenue</b>			
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
<b>SUBTOTAL OTHER OPERATING REVENUE</b>			
11	(sum of lines 4 thru 10)	\$	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	29,692	13
<b>SUBTOTAL Non-Operating Revenue</b>			
14	(sum of lines 12 and 13)	\$ 29,692	14
<b>D. Other Revenue (specify):</b>			
15	VENDING COMMISSIONS	293	15
16			16
<b>SUBTOTAL Other Revenue</b>			
17	(sum of lines 15 and 16)	\$ 293	17
<b>TOTAL REVENUE</b>			
18	(sum of lines 3, 11, 14 and 17)	\$ 3,683,717	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	670,183	19
20	Health Care/ Personal Care	401,541	20
21	General Administration	1,383,618	21
<b>B. Capital Expense</b>			
22	Ownership	1,451,668	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
<b>TOTAL EXPENSES</b>			
28	(sum of lines 19 thru 27)	\$ 3,907,010	28
<b>Income Before Income Taxes</b>			
29	(line 18 minus line 28)	\$ (223,293)	29
<b>Income Taxes</b>			
30		\$	30
<b>NET INCOME OR LOSS FOR THE YEAR</b>			
31	(line 29 minus line 30)	\$ (223,293)	31



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

LINE		TOTAL
	<b>GENERAL EXPENSES</b>	
1	FOOD STAMP REVENUE	(42,766)
3	CABLE TV - RESIDENT ROOMS	(1,119)
1	SALES TAX ON FOOD	(1,303)
		(45,188)
	<b>HEALTH CARE AND PROGRAMS</b>	
		0
	<b>GENERAL ADMINISTRATION</b>	
10	BANK CHARGES	(2,914)
10	PENALTIES	(1,099)
14	POLITICAL CONTRIBUTIONS	(150)
14	BAD DEBTS	(19,934)
		0
		(24,097)
	<b>OWNERSHIP</b>	
17	STRAIGHTLINE DEPRECIATION ADJ.	(18,351)
18	INTEREST INCOME	(29,692)
		0
		(48,043)
	<b>GRAND TOTAL - COLMN 5</b>	<b>(117,328)</b>