

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2016  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2016)**

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. Facility ID Number:</b> <u>1000138</u></p> <p><b>Facility Name:</b> <u>Evergreen Place of Decatur</u></p> <hr/> <p><b>Address:</b> <u>4825 East Evergreen</u> <u>Decatur</u> <u>62521</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>Macon</u></p> <p><b>Telephone Number:</b> ( <u>217</u> ) <u>864-4300</u> Fax # ( )</p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>2012</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>Dave Underwood</u> <b>Telephone Number:</b> ( <u>309</u> ) <u>823-7135</u></p> <p><b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<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>01/01/16</u> to <u>12/31/16</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%; vertical-align: top;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>David M. Underwood</u></td> <td></td> </tr> <tr> <td></td> <td colspan="2">(Title) <u>Executive VP &amp; CFO</u></td> </tr> </table> <table border="1" style="width:100%"> <tr> <td rowspan="4" style="width:20%; vertical-align: top;"><b>Paid Preparer</b></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) ( ) _____ Fax # ( ) _____</td> <td></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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>David M. Underwood</u>			(Title) <u>Executive VP &amp; CFO</u>		<b>Paid Preparer</b>	(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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Facility Name: Evergreen Place of Decatur

Report Period Beginning:

01/01/16

Ending:

12/31/16

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	256,622	288,593		545,215		545,215	1
2	Housekeeping, Laundry and Maintenance	103,724	54,173		157,897		157,897	2
3	Heat and Other Utilities			242,420	242,420		242,420	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>360,346</b>	<b>342,766</b>	<b>242,420</b>	<b>945,532</b>		<b>945,532</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	719,353	6,047	17,084	742,484		742,484	6
7	Activities and Social Services	52,238	10,123		62,361		62,361	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>771,591</b>	<b>16,170</b>	<b>17,084</b>	<b>804,845</b>		<b>804,845</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	246,229	16,241	308,138	570,608	(62,533)	508,075	10
11	Marketing Materials, Promotions and Advertising			64,927	64,927		64,927	11
12	Employee Benefits and Payroll Taxes			271,234	271,234		271,234	12
13	Insurance-Property, Liability and Malpractice			41,453	41,453		41,453	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>246,229</b>	<b>16,241</b>	<b>685,752</b>	<b>948,222</b>	<b>(62,533)</b>	<b>885,689</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,378,166</b>	<b>375,177</b>	<b>945,256</b>	<b>2,698,599</b>	<b>(62,533)</b>	<b>2,636,066</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			523,481	523,481		523,481	17
18	Interest			562,714	562,714	(1,497)	561,217	18
19	Real Estate Taxes			383,324	383,324		383,324	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			15,369	15,369		15,369	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>1,484,888</b>	<b>1,484,888</b>	<b>(1,497)</b>	<b>1,483,391</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,378,166</b>	<b>375,177</b>	<b>2,430,144</b>	<b>4,183,487</b>	<b>(64,030)</b>	<b>4,119,457</b>	<b>24</b>

Facility Name: Evergreen Place of Decatur

Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	3.19	\$ 25.04	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	19.86	12.11	3
4	Activity Director & Assistants	1.86	13.01	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	11.64	10.08	7
8	Dishwashers			8
9	Maintenance Workers	0.92	21.71	9
10	Housekeepers	3.14	8.53	10
11	Laundry			11
12	Managers			12
13	Other Administrative	4.05	17.32	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>44.65</b>	<b>\$ 12.96</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	Heritage Enterprises Inc	50.0%		\$ 275,000	1
2	Grand Oaks Estates LLC	50.0%		275,000	2
3					3
4					4
5					5
				<b>Total</b>	<b>6</b>
				\$ 550000	

VI. (B) Management fees paid to unrelated parties

	NAME and FUNCTION	Amount of Fee	
1	Heritage Operations Group LLC	\$ 221,653	1
2			2
		<b>Total</b>	<b>3</b>
		\$ 221,653	

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
None			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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).

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VIII. OWNERSHIP COSTS

A. Purchase price of land 528,746 Year land was acquired 2012

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	113				\$ 10,601,024	\$ 306,137		\$ 306,137	\$	\$ 1,372,135	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Five (5) Eyewash Station Construction		2013	3,392						6
7		Cable TV Installation-first installment		2013	22,394						7
8		Cable TV Installation-second installment		2014	28,210						8
9		Vertical PTAC cooler		2016	4,705						9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 10,659,725	\$ 306,137		\$ 306,137	\$	\$ 1,372,135	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	\$ 1,527,116	\$ 217,344	\$ 217,344	\$		\$ 972,136	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 1,527,116	\$ 217,344	\$ 217,344	\$		\$ 972,136	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: Evergreen Place of Decatur

Report Period Beginning: 01/01/16

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**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: None

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**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		<b>A. Directly Facility Related</b>										
		<b>Long-Term</b>										
1		Lancaster Pollard		xx	Mortgage	/ /	\$	11,532,646	/ /		\$	562,714
2						/ /			/ /			2
3						/ /			/ /			3
		<b>Working Capital</b>										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		<b>TOTAL Facility Related</b>					\$	11,532,646			\$	562,714
		<b>B. Non-Facility Related</b>										
8		Interest				/ /			/ /			-1,497
9						/ /			/ /			9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$	11,532,646			\$	561,217

\* 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: Evergreen Place of Decatur

Report Period Beginning: 01/01/16

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12/31/16

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,009,258	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	664,112		3
4	Supply Inventory (priced <u>FIFO</u> )	13,599		4
5	Short-Term Investments			5
6	Prepaid Insurance	84,522		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Resident Trust</u>	9,047		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,780,538	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,985,992		13
14	Buildings, at Historical Cost	10,659,725		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,527,116		16
17	Accumulated Depreciation (book methods)	(2,344,271)		17
18	Deferred Charges	217,772		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 (sum of lines 11 thru 23)</b>	\$ 12,046,334	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 13,826,872	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 140,642	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	311,451		31
32	Accrued Interest Payable	36,039		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<u>Resident Trust</u>	9,047		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 497,179	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,532,646		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 (sum of lines 38 thru 43)</b>	\$ 11,532,646	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 12,029,825	\$	45
46	<b>TOTAL EQUITY</b>	\$ 1,797,047	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 13,826,872	\$	47

\*(See instructions.)

Facility Name: Evergreen Place of Decatur

Report Period Beginning: 01/01/16

Ending:

12/31/16

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

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 4,412,195	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 4,412,195</b>	<b>3</b>
<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	20,939	8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 20,939</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	1,497	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 1,497</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	Activity Fund	(158)	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ (158)</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 4,434,473</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	945,532	19
20	Health Care/ Personal Care	804,845	20
21	General Administration	948,222	21
<b>B. Capital Expense</b>			
22	Ownership	1,484,888	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 4,183,487</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 250,986</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 250,986</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$	32
33	Private Pay - Net Inpatient Revenue		33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$</b>	<b>37</b>

Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Adjustment Line #	Amount
PETTY CASH	1,009,258				1,009	1,009 CASH 1,009,258
CASH IN BANK					1,100	1,100 ACCTS RI 827,837
CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. I -163,725
ACCOUNTS RECEIVABLE	664,112				1,110	1,110 ACCTS RECEIV-M/C
MEDICARE RECEIVABLES					1,125	1,125 ACCTS RECEIV-IPA
IPA INCOME RECEIVABLE					1,135	1,135 ACCTS RECEIV-IC
MEDICARE COST REPORT					1,140	1,140 UNAPPLIED CASH RECEIPTS
ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID 84,522
A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
PREPAID INSURANCE	84,522				1,310	1,310 SUPPLIES 13,599
OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
FOOD INVENTORY					1,409	1,409 LAND 1,985,992
SUPPLIES INVENTORY	13,599				1,450	1,450 FURNITU 1,527,116
LAND	1,985,992				1,460	ACCUM I -972,136
FURNITURE & EQUIPMENT	1,527,116				1,475	1,475 BUILDING 10,659,725
ACCUM DEPR-FURN & EQUIP	-972,136				1,490	1,490 ACCUM I -1,372,135
BUILDING & IMPROVEMENT	10,659,725				1,530	1,530 RESIDENT 9,047
ACCUM DEPR-BUILDING	-1,372,135				1,550	1,550 LOAN FEI 217,772
RESIDENT FUNDS	9,047				1,551	1,551 LOAN FEES ADDED
LOAN FEES	217,772				1,850	1,850 INTERCO 0
REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN' -140,642
REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
INTRACOMPANY	0				2,100	2,100 ACCRUEI 0
ACCOUNTS PAYABLE	-140,642				2,100	2,100 PR CLEARING-BENEFITS
BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
ACCRUED PAYROLL	0				2,110	2,110 ACCRUEI 0
ACCRUED VACATION PAY	0				2,120	2,120 U.C. TAXES PAYABLE
UC TAXES PAYABLE					2,125	2,125 FICA TAX 0
FICA TAX PAYABLE	0	0			2,130	2,130 FEDERAL W/H TAX PAYABLE
FIT PAYABLE					2,140	2,140 STATE W/H TAX PAYABLE
STATE W/H PAYABLE		0			2,152	2,152 WORKERS COMP ACCRUAL
EARNED INCOME CREDIT					2,225	2,225 EMPLOYEEE INSURANCE REFUND
UC FED CREDIT REDUCTION					2,230	2,230 PAYROLL SAVINGS
PAYROLL SAVINGS					2,235	2,240 UNITED FUND