

		FOR BHF USE			

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**Supportive Living Facility**

**2018  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2018)**

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>1000021</u></p> <p><b>Facility Name:</b> <u>Asbury Court</u></p> <hr/> <p><b>Address:</b> <u>1750 S Elmhurst Rd</u> <u>Des Plaines</u> <u>60018</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>( 847 ) 228-1500</u> <b>Fax #</b> <u>(847 ) 228-1579</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>2/28/03</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Michael Zahtz</u> <b>Telephone Number:</b> <u>( 847 ) 676-1700</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <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>1/1/18</u> to <u>12/31/18</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 style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;"><b>Officer or Administrator of Provider</b></td> <td style="border: none;">(Signed) _____ (Type or Print Name) <u>Michael Zahtz</u> (Title) <u>CFO</u></td> </tr> <tr> <td style="border: none;"><b>Paid Preparer</b></td> <td style="border: none;">(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u></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) _____ (Type or Print Name) <u>Michael Zahtz</u> (Title) <u>CFO</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Michael Zahtz</u> (Title) <u>CFO</u>							
<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>							

Facility Name Asbury Court

Report Period Beginning: 1/1/18 Ending: 12/31/18

**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	121	Single Unit Apartment	121	44,165	1
2	29	Double Unit Apartment	29	10,585	2
3		Other		10,101	3
4	150	TOTALS	150	64,851	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	41,064	2,739		43,803	5
6	Double Unit	19,117	1,085		20,202	6
7	Other					7
8	TOTALS	60,181	3,824		64,005	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.70%

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

1,524 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: 12/31/18 Fiscal Year:           

\* 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 principal?             
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 principal?             
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 principal?             
If no, explain.

Facility Name: Asbury Court

Report Period Beginning:

1/1/18

Ending:

12/31/18

## 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	395,762	54,138	409,291	859,191		859,191	1
2	Housekeeping, Laundry and Maintenance	243,143	81,608	140,402	465,153		465,153	2
3	Heat and Other Utilities			249,339	249,339		249,339	3
4	Other (specify): Scavenger			32,921	32,921		32,921	4
5	<b>TOTAL General Services</b>	<b>638,905</b>	<b>135,746</b>	<b>831,953</b>	<b>1,606,604</b>		<b>1,606,604</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	590,304	11,275	2,219	603,798		603,798	6
7	Activities and Social Services	66,610	11,681		78,291		78,291	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>656,914</b>	<b>22,956</b>	<b>2,219</b>	<b>682,089</b>		<b>682,089</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	249,431	54,940	626,725	931,096	63,710	994,806	10
11	Marketing Materials, Promotions and Advertising	91,367	42,234	190,034	323,635		323,635	11
12	Employee Benefits and Payroll Taxes	238,905			238,905		238,905	12
13	Insurance-Property, Liability and Malpractice	122,661			122,661	33,528	156,189	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>702,364</b>	<b>97,174</b>	<b>816,759</b>	<b>1,616,297</b>	<b>97,238</b>	<b>1,713,535</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,998,183</b>	<b>255,876</b>	<b>1,650,931</b>	<b>3,904,990</b>	<b>97,238</b>	<b>4,002,228</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			102,669	102,669	517,121	619,790	17
18	Interest					863,231	863,231	18
19	Real Estate Taxes					401,482	401,482	19
20	Rent -- Facility and Grounds			1,877,761	1,877,761	(1,877,761)		20
21	Rent -- Equipment			7,606	7,606		7,606	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>1,988,036</b>	<b>1,988,036</b>	<b>(95,927)</b>	<b>1,892,109</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,998,183</b>	<b>255,876</b>	<b>3,638,967</b>	<b>5,893,026</b>	<b>1,311</b>	<b>5,894,337</b>	<b>24</b>

Facility Name: Asbury Court

Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 46.99	1
2	Licensed Practical Nurses	2	27.69	2
3	Certified Nurse Assistants	9	14.11	3
4	Activity Director & Assistants	1	15.36	4
5	Social Service Workers			5
6	Head Cook	1	24.78	6
7	Cook Helpers/Assistants	8	11.81	7
8	Dishwashers	2	10.93	8
9	Maintenance Workers	2	22.09	9
10	Housekeepers	4	10.38	10
11	Laundry			11
12	Managers	1	74.00	12
13	Other Administrative	5	14.71	13
14	Clerical	1	56.55	14
15	Marketing	2	34.47	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>38</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				\$	1
2					2
3					3
4					4
5					5
				<b>Total</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
Asbury Gardens		North Aurora	
Asbury Gardens Nursing and Rehab		North Aurora	
Asbury of Kankakee Supportive Living		Kankakee	
Asbury Court Nursing & Rehabilitation		Des Plaines	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Des Plaines Property LLC				Property	
Asbury Healthcare				Management Co.	

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: Asbury Court

Report Period Beginning:

1/1/18

Ending:

12/31/18

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					\$	\$		\$	\$	\$	1
2											2
3											3
4											4
5											5
	<b>Improvement Type</b>										
6	See attachment2										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)				\$	\$		\$	\$	\$	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	\$	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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: Asbury Court

Report Period Beginning: 1/1/18

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**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: \_\_\_\_\_

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

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**

	Name of Lender	2		3	4	6		7	8	9						
		Related**				Purpose of Loan	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO									Original	Balance			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1					/ /	\$	\$	/ /		\$	1					
2					/ /			/ /			2					
3					/ /			/ /			3					
	<b>Working Capital</b>															
4					/ /			/ /			4					
5					/ /			/ /			5					
6					/ /			/ /			6					
7	<b>TOTAL Facility Related</b>					\$	\$			\$	7					
	<b>B. Non-Facility Related</b>															
8					/ /			/ /			8					
9					/ /			/ /			9					
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	\$			\$	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: Asbury Court

Report Period Beginning: 1/1/18

Ending:

12/31/18

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,232,671	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>325,000</u> )	1,781,019		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,839		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	87,629		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,192,158	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	3,917,197		15
16	Equipment, at Historical Cost	479,165		16
17	Accumulated Depreciation (book methods)	(2,290,675)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,107,187	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,299,345	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 466,815	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	85,237		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,815		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	Management Fee Payable	40,391		35
36	See Attachment I	57,728		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 752,986	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			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>	\$	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 752,986	\$	45
46	<b>TOTAL EQUITY</b>	\$ 4,546,359	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 5,299,345	\$	47

\*(See instructions.)

Facility Name: Asbury Court

Report Period Beginning: 1/1/18

Ending:

12/31/18

## 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	\$ 6,598,633	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 6,598,633</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services	570	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	1,690	8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 2,260</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	32,942	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 32,942</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	Rent	10,905	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 10,905</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 6,644,740</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	1,606,604	19
20	Health Care/ Personal Care	682,089	20
21	General Administration	1,713,535	21
<b>B. Capital Expense</b>			
22	Ownership	1,892,109	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>\$ 5,894,337</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 750,403</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$ 10,840</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 739,563</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 4,426,753	32
33	Private Pay - Net Inpatient Revenue	2,171,880	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>\$ 6,598,633</b>	<b>37</b>

**Pg8 Line 36 Other:**

Accrued Vacation and Sick	28,299.00
Accrued Expenses	36,708.00
Due to Affiliates	195.00
Due to Residents	2,669.00
Clearing Acct	(12,275.00)
Payroll W/H Acct	2,132.00
Total	<u><u>57,728.00</u></u>

**Pg4 Related Party Expenses**

VII. C.

Description	Amount
Accounting, Billing, Payroll, and Consulting Services	144,314.21
Property Taxes	401,482.00
Insurance	33,528.00
Depreciation	589,083.00
Interest	863,231.00
Other Fees	6,004.00
Amortization Expense	30,707.00
Professional Fees	57,706.00
<b>Total Related Party Expenses</b>	<u><u>2,126,055</u></u>

**Pg3 Expenses Adjustments:**

Professional Fees	63,710	pg. 3 IV. 10
Depreciation adj.	(102,669.00)	pg. 3 IV. 17
Property taxes	401,482.00	pg. 3 IV. 19
Insurance	33,528.00	pg. 3 IV. 13
Interest	863,231.00	pg. 3 IV. 18
Depreciation	619,790.00	pg. 3 IV. 17
Rent	(1,877,761)	pg. 3 IV. 20
<b>Total Adjustments</b>	<u><u>1,311</u></u>	



Account	Debit	Credit	Balance
1000			1000.00
1010			1010.00
1020			1020.00
1030			1030.00
1040			1040.00
1050			1050.00
1060			1060.00
1070			1070.00
1080			1080.00
1090			1090.00
1100			1100.00
1110			1110.00
1120			1120.00
1130			1130.00
1140			1140.00
1150			1150.00
1160			1160.00
1170			1170.00
1180			1180.00
1190			1190.00
1200			1200.00
1210			1210.00
1220			1220.00
1230			1230.00
1240			1240.00
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