

		FOR BHF USE			

LL2

**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>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>  <small>Number City Zip Code</small></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> <tr> <td><b>None</b></td> <td></td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>David M Underwood</u> <b>Telephone Number:</b> ( ) _____  <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 _____		<b>None</b>			<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>1/1/2018</u> to <u>12/31/2018</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%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>David M Underwood</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>EVP/CFO</u></td> <td></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) ( ) _____</td> <td>Fax # ( ) _____</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>EVP/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: 1/1/2018 Ending: 12/31/2018

**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	113	Single Unit Apartment	113	41,245	1
2		Double Unit Apartment			2
3		Other			3
4	113	TOTALS	113	41,245	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	21,290	14,239		35,529	5
6	Double Unit					6
7	Other					7
8	TOTALS	21,290	14,239		35,529	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 86.14%

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

None 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)

None

H. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year:                      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? N 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? N 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? N If yes, did the facility make all of the required payments of interest and principal?                     

If no, explain.

Facility Name: Evergreen Place of Decatur

Report Period Beginning:

1/1/2018

Ending: 12/31/2018

## 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	266,952	300,728		567,680		567,680	1
2	Housekeeping, Laundry and Maintenance	106,201	56,107		162,308		162,308	2
3	Heat and Other Utilities			224,315	224,315		224,315	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>373,153</b>	<b>356,835</b>	<b>224,315</b>	<b>954,303</b>		<b>954,303</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	799,054	6,237	12,191	817,482		817,482	
7	Activities and Social Services	55,217	8,961		64,178		64,178	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>854,271</b>	<b>15,198</b>	<b>12,191</b>	<b>881,660</b>		<b>881,660</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	240,673	20,141	272,832	533,646	(4,109)	529,537	10
11	Marketing Materials, Promotions and Advertising			75,051	75,051		75,051	11
12	Employee Benefits and Payroll Taxes			291,095	291,095		291,095	12
13	Insurance-Property, Liability and Malpractice			33,989	33,989		33,989	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>240,673</b>	<b>20,141</b>	<b>672,967</b>	<b>933,781</b>	<b>(4,109)</b>	<b>929,672</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,468,097</b>	<b>392,174</b>	<b>909,473</b>	<b>2,769,744</b>	<b>(4,109)</b>	<b>2,765,635</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			530,847	530,847		530,847	17
18	Interest			502,751	502,751	(9,791)	492,960	18
19	Real Estate Taxes			306,015	306,015		306,015	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			16,902	16,902		16,902	21
22	Other (sp None)							22
23	<b>TOTAL Ownership</b>			<b>1,356,515</b>	<b>1,356,515</b>	<b>(9,791)</b>	<b>1,346,724</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,468,097</b>	<b>392,174</b>	<b>2,265,988</b>	<b>4,126,259</b>	<b>(13,900)</b>	<b>4,112,359</b>	<b>24</b>

Facility Name: Evergreen Place of Decatur

Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2.83	\$ 28.06	1
2	Licensed Practical Nurses	1.52	21.76	2
3	Certified Nurse Assistants	21.77	12.76	3
4	Activity Director & Assistants	2.03	13.49	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	12.85	10.27	7
8	Dishwashers			8
9	Maintenance Workers	1.05	22.30	9
10	Housekeepers	3.35	8.50	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	4.61	16.82	14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>50.01</b>	<b>\$ 13.57</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%		\$ 200,000	1
2	Grand Oaks Estates LLC	50.0%		200,000	2
3					3
4					4
5					5
				<b>Total</b>	<b>6</b>
				\$ 400000	

VI. (B) Management fees paid to unrelated parties

	NAME and FUNCTION	Amount of Fee	
1	Heritage Operations Group LLC	\$ 218,973	1
2			2
		<b>Total</b>	<b>3</b>
		\$ 218,973	

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 parent organization: None 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: Evergreen Place of Decatur

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	113				\$ 10,601,024	\$ 310,556		\$ 310,556	\$	\$ 1,990,243	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		Split system installation		2017	5,957						10
11		Install flooring - common areas		2017	18,113						11
12		Install smoke and CO2 detectors		2017	12,937						12
13		Upgrade phone and fire panel		2017	23,591						13
14		Split system installation		2018	4,383						14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 10,724,706	\$ 310,556		\$ 310,556	\$	\$ 1,990,243	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	\$ 1,542,869	\$ 220,291	\$ 220,291	\$		\$ 1,411,015	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 1,542,869	\$ 220,291	\$ 220,291	\$		\$ 1,411,015	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: 1/1/2018

Ending: 2/31/2018

**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	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			
	<b>A. Directly Facility Related</b>									
	<b>Long-Term</b>									
1	Lancaster Pollard		x	Mortgage	/ /	\$	11,194,305	/ /		\$ 502,751
2					/ /			/ /		
3					/ /			/ /		
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$	11,194,305			\$ 502,751
	<b>B. Non-Facility Related</b>									
8	Interest Income				/ /			/ /		-9,791
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	11,194,305			\$ 492,960

\* 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: 1/1/2018

Ending: 12/31/2018

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,993,856	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	311,088		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	79,925		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,384,869	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,985,993		13
14	Buildings, at Historical Cost	10,724,707		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,542,869		16
17	Accumulated Depreciation (book methods)	(3,401,258)		17
18	Deferred Charges	208,933		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 1 None</b>	\$ 11,061,244	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 13,446,113	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 102,576	\$	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			31
32	Accrued Interest Payable	355,845		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 458,421	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,194,305		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>	\$ 11,194,305	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 11,652,726	\$	45
46	<b>TOTAL EQUITY</b>	\$ 1,793,387	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 13,446,113	\$	47

\*(See instructions.)

Facility Name: Evergreen Place of Decatur

Report Period Beginning: 1/1/2018

Ending:

12/31/2018

## 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	\$ 4,362,624	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 4,362,624</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	14,960	8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 14,960</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	9,791	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 9,791</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	Miscellaneous	1,901	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 1,901</b>	<b>17</b>
18	<b>TOTAL R None (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 4,389,276</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	954,303	19
20	Health Care/ Personal Care	881,660	20
21	General Administration	933,781	21
<b>B. Capital Expense</b>			
22	Ownership	1,356,515	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>\$ 4,126,259</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 263,017</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>\$ 263,017</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	1,993,856						1,009	1,009	CASH 1,993,856
CASH IN BANK							1,100	1,100	ACCTS RI 471,122
CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. I -160,034
ACCOUNTS RECEIVABLE	311,088						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 53,801
A/R SUSPENSE-REFUNDS							1,220	1,220	OTHER PREPAID EXPENSES
ACCRUED INTEREST REC							1,300	1,300	DIETARY 19,146
PREPAID INSURANCE	79,925						1,310	1,310	SUPPLIES 6,978
OTHER PREPAID EXPENSES							1,320	1,320	LINEN INVENTORY
FOOD INVENTORY							1,409	1,409	LAND 1,985,993
SUPPLIES INVENTORY							1,450	1,450	FURNITU 1,542,869
LAND	1,985,993						1,460		ACCUM I -1,411,015
FURNITURE & EQUIPMENT	1,542,869						1,475	1,475	BUILDING 10,724,707
ACCUM DEPR-FURN & EQUIP	-1,411,015						1,490	1,490	ACCUM I -1,990,243
BUILDING & IMPROVEMENT	#####						1,530	1,530	RESIDENT 8,609
ACCUM DEPR-BUILDING	-1,990,243						1,550	1,550	LOAN FEI 208,933
RESIDENT FUNDS	8,609						1,551	1,551	LOAN FEES ADDED
LOAN FEES	208,933						1,850	1,850	INTERCO 0
REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUN' -102,576
REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE
INTRACOMPANY	0						2,100	2,100	ACCRUEI 0
ACCOUNTS PAYABLE	-102,576						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