		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045575

Facility Name: MARKLUND MILL CREEK HOME #1

Address: 1 South 383 Wyatt Drive (Number) Geneva (City) 60134 (Zip Code)

County: Kane

Telephone Number: (630) 593-5500 **Fax #** (630) 593-5501

IDPA ID Number: 36-2652532005

Date of Initial License for Current Owners: 08/25/03

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL		
	[X] Charitable Corp.		[ ] Individual		[ ] State		
	[ ] Trust		[ ] Partnership		[ ] County		
IRS Exemption Code	501 (c) 3		[ ] Corporation		[ ] Other		
			[ ] "Sub-S" Corp.				
			[ ] Limited Liability Co.				
			[ ] Trust				
			[ ] Other				

In the event there are further questions about this report, please contact:
Name: Lisa Lipira **Telephone Number:** (630) 593-5479

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 08/25/03 to 06/30/04 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Lisa L. Lipira
(Title) CFO/Executive Director

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MARKLUND MILL CREEK HOME #1 # 0045575 Report Period Beginning: 08/25/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	4,976	6
7	16	TOTALS	16	4,976	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,277	620		4,897	13
14	TOTALS	4,277	620		4,897	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.41%

D. How many bed-hold days during this year were paid by Public Aid?
5 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/25/03

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/04 Fiscal Year: 06/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MARKLUND MILL CREEK HOME #1 # 0045575 **Report Period Beginning:** 08/25/03 **Ending:** 06/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	39,436	4,501	2,186	46,123		46,123		46,123			1
2	Food Purchase		30,843		30,843		30,843		30,843			2
3	Housekeeping	21,965	6,674		28,639		28,639		28,639			3
4	Laundry	3,432	4,749		8,181		8,181		8,181			4
5	Heat and Other Utilities			24,250	24,250		24,250		24,250			5
6	Maintenance	17,160	3,275	10,199	30,634		30,634		30,634			6
7	Other (specify):* **Disposal**			3,680	3,680		3,680		3,680			7
8	**TOTAL General Services**	81,993	50,042	40,315	172,350		172,350		172,350			8
	B. Health Care and Programs											
9	Medical Director			1,754	1,754		1,754		1,754			9
10	Nursing and Medical Records	560,806	26,632	202,551	789,989		789,989		789,989			10
10a	Therapy	26,530	1,336	1,275	29,141		29,141		29,141			10a
11	Activities	10,487	4,493	586	15,566		15,566		15,566			11
12	Social Services	9,057			9,057		9,057		9,057			12
13	Nurse Aide Training		42		42		42		42			13
14	Program Transportation	9,651		5,846	15,497		15,497		15,497			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	616,531	32,503	212,012	861,046		861,046		861,046			16
	C. General Administration											
17	Administrative	13,998			13,998		13,998		13,998			17
18	Directors Fees											18
19	Professional Services			9,059	9,059		9,059	(5,790)	3,269			19
20	Dues, Fees, Subscriptions & Promotions			21,581	21,581		21,581	(9,034)	12,547			20
21	Clerical & General Office Expenses	61,590	17,667	9,403	88,660	(1,128)	87,532		87,532			21
22	Employee Benefits & Payroll Taxes			149,214	149,214		149,214		149,214			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,494	1,494		1,494		1,494			24
25	Other Admin. Staff Transportation			2,561	2,561		2,561		2,561			25
26	Insurance-Prop.Liab.Malpractice			21,615	21,615		21,615		21,615			26
27	Other (specify):* **Fund-raising/promo**			7,266	7,266		7,266	(7,266)				27
28	**TOTAL General Administration**	75,588	17,667	222,193	315,448	(1,128)	314,320	(22,090)	292,230			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	774,112	100,212	474,520	1,348,844	(1,128)	1,347,716	(22,090)	1,325,626			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MARKLUND MILL CREEK HOME #1 #0045575 Report Period Beginning: 08/25/03 Ending: 06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			59,726	59,726		59,726	(15,557)	44,169			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,394	2,394		2,394	(2,394)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			24,424	24,424		24,424	(24,424)				34
35	Rent-Equipment & Vehicles					1,128	1,128		1,128			35
36	Other (specify):*											36
37	**TOTAL Ownership**			86,544	86,544	1,128	87,672	(42,375)	45,297			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,033	36,033		36,033		36,033			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			36,033	36,033		36,033		36,033			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	774,112	100,212	597,097	1,471,421		1,471,421	(64,465)	1,406,956			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MARKLUND MILL CREEK HOME #1 # 0045575 Report Period Beginning: 08/25/03 Ending: 06/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	2,394	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	9,034	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	5,790	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	7,266	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Non-care Related Assets	15,557	30		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 40,041		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	24,424	34	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 24,424		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 64,465		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

MARKLUND MILL CREEK HOME #1

ID# 0045575

Report Period Beginning: 08/25/03

Ending: 06/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Fundraising/Promotional	$ 24,424	34	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	24,424		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number MARKLUND MILL CREEK HOME #1 # 0045575 Report Period Beginning: 08/25/03 Ending: 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	5,790	0	0	0	0	0	0	0	0	0	0	5,790	19
20	Fees, Subscriptions & Promotions	9,034	0	0	0	0	0	0	0	0	0	0	9,034	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	7,266	0	0	0	0	0	0	0	0	0	0	7,266	27
28	**TOTAL General Administration**	22,090	0	0	0	0	0	0	0	0	0	0	22,090	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	22,090	0	0	0	0	0	0	0	0	0	0	22,090	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MARKLUND MILL CREEK HOME #1 # 0045575 **Report Period Beginning:** 08/25/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	2,394	0	0	0	0	0	0	0	0	0	0	2,394	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	48,848	0	0	0	0	0	0	0	0	0	0	48,848	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	51,242	0	0	0	0	0	0	0	0	0	0	51,242	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	73,332	0	0	0	0	0	0	0	0	0	0	73,332	45

Facility Name & ID Number MARKLUND MILL CREEK HOME #1 # 0045575 Report Period Beginning: 08/25/03 Ending: 06/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MARKLUND MILL CREEK HOME #1 # 0045575 Report Period Beginning: 08/25/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MARKLUND MILL CREEK HOME #1 # 0045575 Report Period Beginning: 08/25/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Cost Budget	12,876,286	12,876,286	$ 457	$	1,202,442	$ 43	1
2	2	Food	Direct Cost Budget	12,876,286	12,876,286	2,134		1,202,442	199	2
3	3	Housekeeping	Direct Cost Budget	12,876,286	12,876,286	12,900		1,202,442	1,205	3
4	5	Utilities	Direct Cost Budget	12,876,286	12,876,286	61,629		1,202,442	5,755	4
5	6	Maintenance	Direct Cost Budget	12,876,286	12,876,286	22,512		1,202,442	2,102	5
6	7	Disposal	Direct Cost Budget	12,876,286	12,876,286	30,499		1,202,442	2,848	6
7	13	BNATP	Direct Cost Budget	12,876,286	12,876,286	450		1,202,442	42	7
8	14	Transportation	Direct Cost Budget	12,876,286	12,876,286	233		1,202,442	22	8
9	19	Professional Services	Direct Cost Budget	12,876,286	12,876,286	35,004		1,202,442	3,269	9
10	20	Fees, Subscription	Direct Cost Budget	12,876,286	12,876,286	129,044		1,202,442	12,051	10
11	21	Clerical/Office	Direct Cost Budget	12,876,286	12,876,286	656,826	488,661	1,202,442	73,134	11
12	22	Benefits	Direct Cost Budget	12,876,286	12,876,286	94,192		1,202,442	11,070	12
13	24	Travel & Seminars	Direct Cost Budget	12,876,286	12,876,286	13,428		1,202,442	1,254	13
14	25	Staff Transportaion	Direct Cost Budget	12,876,286	12,876,286	22,028		1,202,442	2,057	14
15	26	Insurance	Direct Cost Budget	12,876,286	12,876,286	14,004		1,202,442	1,308	15
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25	TOTALS					$ 1,095,340	$ 488,661		$ 116,359	25