



NURSING FACILITY FINANCIAL REPORT

TO BE USED IN ACCORDANCE WITH THE PROVISIONS OF 405 IAC 1-14.6

SEE INSTRUCTIONS BEFORE COMPLETING (REV. 1/06)

Round all amounts to nearest whole number or dollar			AIM Number:		
Type of Transmission:		Period of Report			
<input type="checkbox"/> [11101] Annual Report		[20101] From:		[20102] To:	
[12101] Name of Facility			[11301] Employer I.D. Number		
Mailing Address					
[12102] Street or P. O. Box			[12103] City	[12104] State	[12105] Zip
Physical Address (If Different)					
[12106] Street			[12107] City	[12108] State	[12109] Zip
[131] Type of Control: (Check One)			[12110] FYE for Tax Reporting		
Proprietary For-Profit		Voluntary Non-Profit	Government	[132] Please check if applicable:	
<input type="checkbox"/> [11] Individual <input type="checkbox"/> [12] Partnership <input type="checkbox"/> [13] C Corporation <input type="checkbox"/> [14] S Corporation <input type="checkbox"/> [15] Other (Specify)		<input type="checkbox"/> [21] Church <input type="checkbox"/> [22] Other (Specify)	<input type="checkbox"/> [31] State <input type="checkbox"/> [32] County <input type="checkbox"/> [33] City <input type="checkbox"/> [34] Other (Specify)	Facility is: <input type="checkbox"/> [41] Purchased/Owned <input type="checkbox"/> [42] Capital Lease <input type="checkbox"/> [43] Operating Lease	
[151] Facility is: <input type="checkbox"/> [51] Licensed as Hospital Based <input type="checkbox"/> [52] Registered as a Continuing Care Retirement Community					
Did facility status as a licensed hospital based nursing facility change during the reporting year? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes: Effective date facility became licensed: / / Effective date facility licensure terminated / /					
Did facility status as a continuing care retirement community change during the reporting year? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes: Effective date facility became registered: / / Effective date facility registration terminated / /					
Is this Provider Medicare Certified?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
CERTIFICATION STATEMENT					
This is to certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, complete, and related to patient care. Expenses not related to patient care have been appropriately identified or removed. I understand that this information is submitted for the purpose of developing payment rates under the Indiana Medicaid Program, and the ultimate payment and satisfaction of claims will be based upon the information contained herein. I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law. Declaration of preparer is based on all information of which the preparer has any knowledge. Preparer may (but not required) also include a compilation statement. The Certification Statement submitted to the Rate Setting Contractor must contain original signatures.					
Name of Authorized Person		Title / Position		Name of Facility	
Signature of Authorized Person		Date		Telephone Number	
				()	
Name of Preparer		Title / Position		Address of Preparer	
Signature of Preparer		Date		Telephone Number	
				()	

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SCHEDULE A

Statistical Data	Line No.	Nursing Facility [01]	Other Nursing [03]	Other [04]
Beds Available	142			
Total Bed Days Available	143			
Total Patient Days - Medicaid (From Schedule I)	144			
Total Patient Days - Medicare (From Schedule I)	145			
Total Patient Days - All Patients (From Schedule I)	148			
Occupancy Percentage (Line 148/Line 143)	151			
Medicaid Utilization (Line 144/Line 148)	152			
Total Hours Worked During Period - (From Schedule E)	153			
Average Hours Worked PPD (Line 153/Line 148)	158			

SCHEDULE B

[16100] Accounting Method - (Check One) If cash, then submit beginning and ending balance for accounts payable, salaries payable, and inventories on a separate sheet.

(1) Accrual

(2) Modified Cash

(3) Cash

[16200] Related Party Transactions - (Check One) Does this cost report include any transactions with organizations that are related to the provider, including working capital loans, as defined by the Rate Setting Criteria? If yes, then submit details in a cover letter on a separate sheet, and report on the appropriate schedules of this form.

(1) Yes

(2) No

SCHEDULE C

Schedule of Charges	Line No.	Private Pay at RYE [01]
Private Room	171	
Two-Bed Room	172	
Three- Bed Room	173	

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See instructions before completing

AIM Number:

SCHEDULE D									
Schedule of Revenue	Line No.	Medicaid [01]	Medicare Part A [02]	Medicare Part B [03]	Private Pay [04]	Other [05]	Total [06]	Nursing Facility [07]	Other [08]
Routine Daily Service	211								
Physical Therapy	231								
Speech and Audiology Therapy	232								
Occupational Therapy	233								
Respiratory Therapy	234								
Sale of Routine Medical Supplies	235								
Sale of Non-Routine Medical Supplies	236								
X-Ray and Laboratory	237								
Pharmacy and Drugs	238								
Parenteral and Enteral Nutrition (PEN)	239								
Florist	241								
Barber / Beauty Shop	242								
Vending Machines	243								
Personal Purchases	244								
Meals Sold to Guests and Employees	245								
Activity Sales	246								
Investment Income - Interest & Dividends	247								
Other Revenue - (Specify)	248								
Less Bad Debt	262								
Less Contractual/Charity Allowances	263								
Less Other Reductions to Revenue	267								
Total	268								

[26810] Have revenues generated from the sale of goods or services to non patients been offset against the cost of such goods and services? (Check one) If no, attach explanation.

(1) Yes

(2) No

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AIM Number:

SCHEDULE E									
Schedule of Expenses	Line No.	Hours Worked [01]	Personnel [02]	Other [03]	Provider Adjustment [24]	Total [04]	Allocation Base [05]	Nursing Facility [06]	Other [09]
Director of Nursing	311								
Registered Nurses	312								
Licensed Practical Nurses	313								
Nurses Aides and Orderlies	314								
Medical Director	315								
Other Nursing	316								
Pool Nursing	317								
Routine Medical Supplies	318								
Non-Routine Medical Supplies	319								
Parenteral and Enteral Nutrition (PEN)	320								
NATCEP Costs	321								
TOTAL NURSING	328								
Dietary Personnel	331								
Dietician	332								
Raw Food	333								
Other Dietary Expense	337								
TOTAL DIETARY	338								
Laundry Personnel	341								
Housekeeping Personnel	342								
Laundry Supplies & Services	343								
Housekeeping Supplies & Services	344								
TOTAL LAUNDRY & HOUSEKEEPING	348								
Plant Operation Personnel	351								
Utilities - Gas, Water, Electric	352								
Repairs and Maintenance	353								
Other Plant Operations	357								
TOTAL PLANT OPERATIONS	358								
Interest on Facilities & Equipment	361								
Depreciation - Building & Fixtures	362								
Depreciation - Moveable Equipment	363								
Building Lease/Rent	364								
Equipment Lease/Rent	365								
Insurance (Fire, Property, etc.)	371								
Real Estate Taxes	373								
Personal Property Taxes	374								
Other Capital Costs	377								
TOTAL CAPITAL	378								

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SCHEDULE E									
Schedule of Expenses	Line No.	Hours Worked [01]	Personnel [02]	Other [03]	Provider Adjustment [24]	Total [04]	Allocation Base [05]	Nursing Facility [06]	Other [09]
Administrator's Salary	381								
Co-Administrators' Salary	382								
Owner, Related Party, Management	383								
Directors' Fees	384								
Other Home Office Personnel	385								
QMRP	388								
Office & Clerical Personnel	389								
Legal & Accounting Fees - See Instructions	391								
Advertising - All Other	392								
Advertising - Help Wanted	393								
Travel Expenses - See Instructions	394								
Telephone	395								
License, Dues & Subscriptions	396								
Office Supplies & Postage	397								
Contributions & Donations	398								
Interest - Working Capital	401								
State Gross Receipts & Income Taxes	402								
Utilization Review Costs	403								
Liability Insurance	404								
Owners' Expense - See Instructions	405								
Consultant Fees	406								
Other General & Administrative (Specify)	407								
TOTAL GENERAL & ADMINISTRATIVE	408								
Payroll Taxes	411								
Health Insurance	412								
Life Insurance - Not in Excess of Limits	413								
Workers' Compensation	414								
Qualifying Pensions	415								
Owners' Benefits - See Instructions	416								
Other Qualifying Benefits (Specify)	417								
TOTAL EMPLOYEE BENEFITS	418								

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SCHEDULE E									
Schedule of Expenses	Line No.	Hours Worked [01]	Personnel [02]	Other [03]	Provider Adjustment [24]	Total [04]	Allocation Base [05]	Nursing Facility [06]	Other [09]
Activity Director	421								
Activity Services	422								
Recreational Services	423								
Social Worker	424								
Activity Supplies	425								
Other Social Service Expenses	426								
Recreational Supplies	427								
TOTAL SOCIAL SERVICES	438								
Physical Therapy	441								
Speech and Audiology Therapy	442								
Occupational Therapy	443								
Respiratory Therapy	444								
TOTAL THERAPY SERVICES	448								
TOTAL ROUTINE COSTS	450								
X-Ray	453								
Laboratory	454								
Florist	455								
Barber/Beauty Shop	456								
Vending Machines	457								
Nursing Facility Quality Assessment Fees	460								
Pharmacy/Drugs	461								
Ambulance	462								
Other (Specify)	463								
TOTAL ANCILLARY	468								
GRAND TOTAL	498								

[49810] Did any of the following costs that are reported on Schedule E incur as a result of an administrative or judicial action or proceeding against any agency of the state or federal government: (a) costs associated with legal fees, (b) costs associated with expert witnesses, (c) accounting fees and consulting fees? If yes, attach a schedule detailing the costs reported, and include the description and line where the cost was reported.

- (1) Yes
 (2) No

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AIM Number:

SCHEDULE F

Allocation Base	Line No.	Allocation Base Code	Total [01]	Nursing Facility [02]	Other [06]
Square Feet	501	1			
Patient Days	502	2			
Bed Days Available	503	3			
Accumulated Costs	504	4			
Total Personnel Costs	505	5			
Director of Nursing Hours	506	6			
R.N. Hours	507	7			
L.P.N. Hours	508	8			
Nurses Aides & Orderlies Hours	509	9			
Non-Routine Medical Supply Revenue	510	10			
Physical Therapy Revenue	511	11			
Speech & Audiology Therapy Revenue	512	12			
Occupational Therapy Revenue	513	13			
Respiratory Therapy Revenue	514	14			
Other (Specify)	515	15			
Other (Specify)	516	16			

SCHEDULE G

Reconciliation of Expenses	Line No.	Financials or Tax Return [01]	Schedule E [02]
Total Expenses from: (Check Source) <input type="checkbox"/> Financial Statements/General Ledger <input type="checkbox"/> Tax Return	551		
Total Expenses per Schedule E - Line 498	552		
Sum of Columns 2 and 3			
Expenses on Financial Statement or Tax Return not on Schedule E Specify	553		
Specify	554		
Specify	555		
Expenses on Schedule E not on Financial Statement or Tax Return Specify	556		
Specify	557		
Specify	558		
Total (columns 1 and 2 should be equal)	559		

SCHEDULE H

Consultant Fees	List all those who received fees or other compensation for consultation services that are not related parties and are not for management functions as defined at 405 IAC 1-14.6-18. Services from a related party should be reported on Schedule M. Attach additional sheets if necessary.			
Name [01]	Line No.	Type of Services Rendered [02]	Schedule E Line No./Column No. [03]	Amount [04]
	571			
	572			
	573			
	574			
	575			
	576			
Total	579			

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SCHEDULE I				
History of Bed Changes	Line No.	Date Beds Were Put Into/Removed From Service [01]	Number of Beds Added/Deleted [02]	Total Number of Beds After Change [03]
At later date of original lease, purchase, construction or 7/1/76	135			
Addition / Deletion	136			
Addition / Deletion	137			
Addition / Deletion	138			
Addition / Deletion	139			
Total number of beds in this facility at latest report year end	150			

Summary of Occupant Days From Census Logs	Line No.	Reserve Days [01]	Factor [02]	Adjusted Reserve Days [03]	Present in Facility [04]	Total [05]	Transfer Total in Column 5 to Schedule A	
							Line	Column
Days in Nursing Facility Medicaid - Non-SCU Days	184		1/2					
Medicaid - Special Care Unit (SCU) Days	185		1/2					
Total Medicaid	186		1/2				144	01
Medicare Days	187						145	01
Private Pay Days	188							
Other Days	189							
Total Nursing Facility	190						148	01
Other Nursing Private Pay Days	194							
Other Nursing Days	195							
Total Other Nursing	196						148	03
Other Private Pay Days	197							
Other Days	198							
Total Other Section	199						148	04
Grand Total	200							

For reserve days, Column 1 times factor in Column 2 is equal to Column 3. For all lines, Column 3 plus Column 4 is equal to Column 5. Column 1 reports occupant days for which a bed is being held but patient is not present in the facility. Column 4 reports occupant days for which patient is actually in the facility for midnight census.

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AIM Number:

SCHEDULE J							
Analysis of Property	Line No.	Agency Use Only [01]	Historical Cost at Beginning of Period [02]	Additions* [03]	Disposals* [04]	Historical Cost at End of Period [05]	Depreciation Expense This Period [06]
Land	651						
Land Improvements	652						
Building & Building Components	653						
Building Improvements	654						
Moveable Equipment	655						
Vehicles & Other Property-Owners' Expense	656						
Vehicles - Other	657						
Other - Specify	658						
Other - Specify	659						
TOTAL	660						

* Please submit detailed information for any addition or disposal in excess of \$5,000 including: date placed in service or disposed of, description and purpose of property, location, and cost basis. Line 660 Column 6 should equal the sum of Lines 362 and 363 of Schedule E.

[66500] Does any item included in this schedule pertain to any property that is not patient related to beds listed in Schedule A? If yes, attach explanation. (1) Yes (2) No

[67102] Was any item included in this schedule acquired directly or indirectly from a related party? If yes, attach explanation. (1) Yes (2) No

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AIM Number:

SCHEDULE K						
Analysis of Property Financing	Line No.	Property Financing #1	Property Financing #2	Property Financing #3	Property Financing #4	Property Financing #5
ID Number - For Ratesetter Use Only	701					
Name of Lender	711					
Are Lender and Borrower Related Parties? (Check One)	712	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
Description of Property Financed	713					
Original Commitment Date of Loan	716					
Beginning Date of Payments	717					
Term of Loan-Amort. Period in Months	718					
Original Amount of Loan	719					
Date of Refinancing This Period (if any)	721					
Unpaid Balance at Beginning of Period	724					
Unpaid Balance at End of Period	725					
Average Unpaid Balance This Period	726					
Is Interest Rate Fixed or Variable? (Check One)	731	<input type="checkbox"/> (1) Fixed <input type="checkbox"/> (2) Variable	<input type="checkbox"/> (1) Fixed <input type="checkbox"/> (2) Variable	<input type="checkbox"/> (1) Fixed <input type="checkbox"/> (2) Variable	<input type="checkbox"/> (1) Fixed <input type="checkbox"/> (2) Variable	<input type="checkbox"/> (1) Fixed <input type="checkbox"/> (2) Variable
If Fixed, Give Interest Rate	732					
If Variable, Average Interest Rate During Period	735					
If Variable, Average Interest Rate at End Period	737					
Amount of Debt Service This Period	741					
Interest Expense This Period	742					
Line Number on Which Expense is Reported	743					
Does Financing Pertain to Only Patient Related Property? (Check One)	748	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No

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AIM Number:

SCHEDULE L					
Analysis of Leased Property	Line No.	Lease No. 1	Lease No. 2	Lease No. 3	Lease No. 4
ID Number - For Ratesetter Use Only	751				
Name of Lessor	761				
Are Lessor and Lessee Related Parties?	762	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
Description of Leased Property	763				
Does Lease Pertain to Only Patient Related Property? (Check One) If No, Attach Allocation Plan.	765	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
Is the Historical Cost Basis of this Property Included in Schedule J? (Check One)	766	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
Date of Commitment on Current Lease	772				
Date of Commitment on Original Lease	773				
Inception Date of Original Lease Agreement*	774				
Minimum Annual Lease Payments Without Executory Costs at Inception Date of Original Lease*	776				
Amount of Lease Payments this Period Without Executory Costs	777				
Line Number on Which Expense is Reported	779				
Incremental Borrowing Rate at Date of Inception*	781				
Lessor's Implicit or Imputed Interest Rate at Date of Inception*	782				
Term of Lease in Months*	783				
Economic Life of Leased Assets in Months*	784				
Fair Market Value of Leased Assets at Date of Inception*	785				
Amount of Guaranteed Residual Value*	786				
Amount of Bargain Purchase Option*	787				
Amount of Bargain Renewal Option*	788				
Is Ownership Transferred to Lessee at End of Lease Term? (Check One)*	789	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
Is Lease Payment Contingent Upon Inflation Index or Interest Rate? (Check One) If Yes, Attach Explanation of Contingencies or Methods of Calculation	792	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
Has an Independent Accountant Ever Made a Determination as to Type of Lease According to GAAP? (Check One)*	795	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
Indicate Type of Lease in Accordance with GAAP (Check One)*	796	<input type="checkbox"/> (1) Capital <input type="checkbox"/> (2) Operating <input type="checkbox"/> (3) Unknown	<input type="checkbox"/> (1) Capital <input type="checkbox"/> (2) Operating <input type="checkbox"/> (3) Unknown	<input type="checkbox"/> (1) Capital <input type="checkbox"/> (2) Operating <input type="checkbox"/> (3) Unknown	<input type="checkbox"/> (1) Capital <input type="checkbox"/> (2) Operating <input type="checkbox"/> (3) Unknown

* These items are technical questions relating to FASB 13 and subsequent pronouncements of the AICPA.

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LEGEND: TYPE OF PARTY - COLUMN 5	
1. OWNER/CONTROL	3. MANAGEMENT PERSONNEL
2. RELATED PARTY	4. RELATED VENDOR

AIM Number: _____

SCHEDULE M

Listing of Owners, Related Parties, and Management			Mark Type of Party [05]	Percent Ownership in This Facility [06]	Hours Worked [07]	Amount of Compensation [08]	Line on Which Comp. Is Reported [09]	Amount of Owner's Expenses [10]	Amount of Vendor Payments [11]	Line on Which Expense is Reported [12]	Related Party Transactions Profit Removed?	
Line No.	Name, City & State [01]/[02]/[03]	Position / Service or Supply [04]									Yes	No
			[13]									
[871]			1 2 3 4								<input type="checkbox"/>	<input type="checkbox"/>
											Profit	\$
[872]			1 2 3 4								<input type="checkbox"/>	<input type="checkbox"/>
											Profit	\$
[873]			1 2 3 4								<input type="checkbox"/>	<input type="checkbox"/>
											Profit	\$
[874]			1 2 3 4								<input type="checkbox"/>	<input type="checkbox"/>
											Profit	\$
[875]			1 2 3 4								<input type="checkbox"/>	<input type="checkbox"/>
											Profit	\$
[876]			1 2 3 4								<input type="checkbox"/>	<input type="checkbox"/>
											Profit	\$
[877]			1 2 3 4								<input type="checkbox"/>	<input type="checkbox"/>
											Profit	\$
[878]			1 2 3 4								<input type="checkbox"/>	<input type="checkbox"/>
											Profit	\$
[879]			1 2 3 4								<input type="checkbox"/>	<input type="checkbox"/>
											Profit	\$
[880]			1 2 3 4								<input type="checkbox"/>	<input type="checkbox"/>
											Profit	\$
[889]	Total											

[89010] Is this facility owned by a publicly traded company? If yes, attach a copy of the latest Annual Report to Stockholders and SEC Form 10-K. (1) Yes (2) No

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SCHEDULE N

Balance Sheet

Assets	Line No.	Beginning of Period		End of Period	
		[01]	[02]	[03]	[04]
Cash	811				
Accounts receivable	812				
Less: Allowance for Bad Debt	813				
Prepaid Expenses	814				
Inventories and Supplies	815				
Intercompany Receivables	816				
All Loans to Owners, Officers & Related Parties*	817				
All Assets Not Related to Patient Care*	818				
Assets Held for Investment*	819				
Property, Plant and Equipment	820				
Less: Accumulated Depreciation	821				
Other Assets (Specify)	822				
Other Assets (Specify)	823				
TOTAL ASSETS	829				
Liabilities and Equity					
Accounts Payable	840				
Other Current liabilities	841				
Intercompany Liabilities	842				
Non-Related Party Working Capital Loans	843				
Related Party Working Capital Loans	844				
Property Financing - Patient Related	845				
Property Financing - Not Related to Patient Care*	846				
All Loans from Owners, Officers & Related Parties*	847				
Other Long Term Liabilities (Specify)	848				
TOTAL LIABILITIES	849				
Owners Equity or Fund Balance					
Owners' Capital - Individual Proprietor	851				
Partners' Capital Account - Partnership	852				
Fund Balance - Not for Profit Entity	853				
Capital Stock - Preferred Stock	854				
Common Stock	855				
Additional Paid-In Capital	856				
Retained Earnings	857				
Less: Cost of Treasury Stock	858				
TOTAL OWNERS' EQUITY OR FUND BALANCE	859				
TOTAL LIABILITIES AND OWNERS' EQUITY	860				

* Attach Explanation

[80200] Check the highest level of service provided by an independent accountant regarding the financial statements covering the report period:

Audit

Review

Compilation

None of the Above

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SCHEDULE O			
Reconciliation of Owners' Equity or Fund Balance			
Beginning of Period Balance (Schedule N, Line 859, Column 2)	901		
Increases:			
Revenues Per Financial Statements or Tax Return	905		
Investment by Owners	906		
Transfers from Home Office	907		
Common Stock Sold	908		
Other (Specify)	909		
Other (Specify)	910		
Total Increases	915		
Decreases:			
Expenses Per Financial Statements or Tax Return	920		
Withdrawal by Owners	921		
Transfers to Home Office	922		
Dividends Paid to Stockholders	923		
Other (Specify)	924		
Other (Specify)	925		
Other (Specify)	926		
Total Decreases	930		
End of Period Balance (Schedule N, Line 859, Column 4)	940		