

		FOR BHF USE			

LL2

Supportive Living Facility

2017

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2017)

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.

I. Facility ID Number: 1000041		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: CHURCHVIEW SUPPORTVE LVG CTR		I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2017 to 12/31/2017 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.																							
Address: 2626 WEST 63RD ST CHICAGO 60629																									
County: COOK																									
Telephone Number: (773) 471-4444 Fax # 773 471-3935																									
Federal Employer ID Number:																									
Date Current Owners were Certified: 3/24/2005		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) Greg Echols</td><td></td></tr><tr><td>(Title) CFO, Gardant Management Solutions</td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) _____</td><td></td></tr><tr><td>(Firm Name & Address) _____</td><td></td></tr><tr><td>(Telephone) () _____</td><td>Fax # () _____</td></tr><tr><td colspan="2">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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) Greg Echols		(Title) CFO, Gardant Management Solutions		(Signed) _____	(Date) _____	Paid Preparer	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____	Fax # () _____	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					
Officer or Administrator of Provider	(Signed) _____				(Date) _____																				
	(Type or Print Name) Greg Echols																								
	(Title) CFO, Gardant Management Solutions																								
	(Signed) _____			(Date) _____																					
Paid Preparer	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) () _____	Fax # () _____																							
	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																								
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☒ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☒ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.			☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☒ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: Thomas Staszak																									
Telephone Number: (815) 935-1992																									
Email Address: _____																									

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	86	Single Unit Apartment	86	31,390	1
2		Double Unit Apartment			2
3		Other			3
4	86	TOTALS	86	31,390	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	27,199	271		27,470	5
6	Double Unit					6
7	Other					7
8	TOTALS	27,199	271		27,470	8

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

87.51%

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

892

 Also, indicate the number of unpaid bed-hold days the SLF had during this year.

23

 (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)

H. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 2017 Fiscal Year: 2017

* 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 principle?
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 principle?
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 principle?
If no, explain.

Facility Name: CHURCHVIEW SUPPORTVE LVG CTR

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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			
	A. General Services							
1	Dietary and Food Purchase	242,434	147,685	2,128	392,247		392,247	1
2	Housekeeping, Laundry and Maintenance	114,922	86,036	59,890	260,848		260,848	2
3	Heat and Other Utilities			198,647	198,647	(9,833)	188,814	3
4	Other (specify): See Page 3 Attachment			76,421	76,421		76,421	4
5	TOTAL General Services	357,356	233,721	337,086	928,163	(9,833)	918,330	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	415,347	11,133		426,480		426,480	6
7	Activities and Social Services	30,633	10,854		41,487		41,487	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	445,980	21,987		467,967		467,967	9
	C. General Administration							
10	Administrative and Clerical	213,897	27,736	252,903	494,536	(9,304)	485,232	10
11	Marketing Materials, Promotions and Advertising	67,350	8,567	48,094	124,011		124,011	11
12	Employee Benefits and Payroll Taxes			304,586	304,586		304,586	12
13	Insurance-Property, Liability and Malpractice			44,063	44,063		44,063	13
14	Other (specify): See Page 3 Attachment			83,918	83,918	(24,482)	59,436	14
15	TOTAL General Administration	281,247	36,303	733,564	1,051,114	(33,786)	1,017,328	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,084,583	292,011	1,070,650	2,447,244	(43,619)	2,403,625	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			497,607	497,607		497,607	17
18	Interest			48,471	48,471	(3,834)	44,637	18
19	Real Estate Taxes			93,427	93,427		93,427	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			11,492	11,492		11,492	21
22	Other (specify): See Page 3 Attachment			170,550	170,550	(8,441)	162,109	22
23	TOTAL Ownership			821,547	821,547	(12,275)	809,272	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,084,583	292,011	1,892,197	3,268,791	(55,894)	3,212,897	24

Facility Name: CHURCHVIEW SUPPORTVE LVG CTR

Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	Inc line 12	\$ Inc line 12	1
2	Licensed Practical Nurses	1	22.80	2
3	Certified Nurse Assistants	12	11.82	3
4	Activity Director & Assistants	Inc line 12	Inc line 12	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	8	11.82	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	11.59	10
11	Laundry			11
12	Managers	5	23.07	12
13	Other Administrative	4	20.74	13
14	Clerical	Inc line 13	Inc line 13	14
15	Marketing	Inc line 12	Inc line 12	15
16	Other			16
17	Total (lines 1 thru 16)	33	\$	17

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

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).

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
Total				\$	6

VI. (B) Management fees paid to unrelated parties Amount of Fee

1	Gardant Management Solutions	\$ 146,906	1
2			2
Total		\$ 146,906	3

OTHER RELATED BUSINESS ENTITIES				
Name	3	City	4	Type of Business 5

Facility Name: CHURCHVIEW SUPPORTVE LVG CTR

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land \$ 1,302,647 Year land was acquired 1998-2000

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	86			2004	\$ 12,319,858	\$ 447,950	27.5	\$ 447,995	\$ 45	\$ 5,981,898	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Leasehold Improvements				300,149	19,534	15	20,010	476	258,544	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)				\$ 12,620,007	\$ 467,484		\$ 468,005	\$ 521	\$ 6,240,442	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	\$ 507,477	\$ 30,123	\$ 101,495	71,372	5	\$ 378,736	18
19					\$		-	19
20	TOTAL (lines 18 and 19)	\$ 507,477	\$ 30,123	\$ 101,495	71,372		\$ 378,736	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: CHURCHVIEW SUPPORTVE LVG CTR Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	TOTAL				\$			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				
	A. Directly Facility Related										
	Long-Term										
1	HARRIS TRUST & SAVING		X	FIRST MORTGAGE	3/1/2003	\$ 7,555,000	\$ 5,625,000	9/1/2033	variable	\$ 48,471	1
2	CITY OF CHICAGO DEPT C		X	Second Mortgage	3/1/2003	4,000,000	4,000,000	3/1/2035	none		2
3											3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 11,555,000	\$ 9,625,000			\$ 48,471	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 11,555,000	\$ 9,625,000			\$ 48,471	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: CHURCHVIEW SUPPORTVE LVG CTR

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 771,047	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (61,765))	469,353		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,764		6
7	Other Prepaid Expenses	3,749		7
8	Accounts Receivable (owners or related parties)	13,137		8
9	Other(specify): See Page 7 Attachment	1,213		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,271,262	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,302,647		13
14	Buildings, at Historical Cost	12,319,858		14
15	Leasehold Improvements, at Historical Cost	300,149		15
16	Equipment, at Historical Cost	507,477		16
17	Accumulated Depreciation (book methods)	(6,619,178)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	205,780		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(205,780)		20
21	Restricted Funds	921,989		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,732,941	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,004,203	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 161,671	\$	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	90,790		31
32	Accrued Interest Payable	478		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	169,506		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 422,445	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	9,396,719		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 9,396,719	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 9,819,164	\$	45
46	TOTAL EQUITY	\$ 185,038	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,004,203	\$	47

*(See instructions.)

Facility Name: CHURCHVIEW SUPPORTVE LVG CTR

Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

		1	
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,847,469	1
2	Discounts and Allowances	(24,532)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,822,937	3
	B. Other Operating Revenue		
4	Special Services	127,747	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	189	8
9	Non-Resident Meals	4,060	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 131,996	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	3,834	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 3,834	14
	D. Other Revenue (specify):		
15	See Page 8 Attachment	878	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 878	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,959,645	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	928,163	19
20	Health Care/ Personal Care	467,967	20
21	General Administration	1,051,114	21
	B. Capital Expense		
22	Ownership	821,547	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 3,268,791	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (309,146)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (309,146)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 2,023,807	32
33	Private Pay - Net Inpatient Revenue	799,130	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,822,937	37

Expenses PG 3 Other

[illegible]

Balance Sheet PG 7 Other, See Attachment

Balance Sheet					
Other Current Assets Detail			Current Liabilities Detail		
		Amt			Amt
1102-9971-0-0	A/R-Employee Advance	-	2111-0040-0-0	Construction Account Payable	-
1102-9972-0-0	A/R-Gardant Mgmt Solutions	-	2112-0100-0-0	Accrued Asset Management Fee	8,600
1102-9973-0-0	A/R-Insurance Reimbursemen	-	2112-0101-0-0	Accrued Partnership Mgmt Fee	53,000
1102-9974-0-0	A/R-Subscription Receivable	-	2112-0102-0-0	Accrued Incentive Mgmt Fee	-
1102-9975-0-0	A/R-CIP	-	2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
1102-9976-0-0	A/R-Other	1,213	2112-0105-0-0	Accrued Liabilities	74,038
1102-9978-0-0	A/R-TIF/Abatement	-	2112-0110-0-0	Accrued Insurance	-
1105-0006-0-0	Security Deposit-Equip & Util	-	2112-0115-0-0	Accrued Developer Fee	-
1105-0009-0-0	Transfer Account	-	2112-0130-0-0	Accrued MIP	-
1105-0012-0-0	Undeposited Funds	-	2112-0140-0-0	Accrued Vacation	-
			2112-0144-0-0	Payroll Union Dues	-
			2112-0146-0-0	Payroll Benefits	-
			2112-0150-0-0	Security Deposits	-
			2112-0154-0-0	Unclaimed Property	14,951
			2112-0155-0-0	Reservation Deposit	-
			2112-0156-0-0	Buy Down Credit	-
			2112-0157-0-0	Unapplied Last Month Rent	-
			2112-0158-0-0	Deferred Gain on Sale	-
			2112-0159-0-0	Unearned Revenue	18,916
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
		1,213			169,506
Other Long Term Assets Detail					
1201-0020-0-0	CIP	-			
1201-0021-0-0	CIP- Land Option Addition	-			
1201-0022-0-0	CIP- Other Addition	-			
		-			

Income Statement PG 8 Other, See Attachment

Income Statement		
Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	(2,722)
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	3,600
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		878