

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 License ID Number: <u>0048066</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Heritage Health Streator</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1525 East Main St</u> <u>Streator</u> <u>61364</u>																									
Number City Zip Code																									
County: <u>LaSalle</u>																									
Telephone Number: <u>(815) 672-4516</u> Fax # <u>()</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>David M Underwood</u></td></tr><tr><td>(Title) <u>EVP & CFO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>David M Underwood</u>	(Title) <u>EVP & CFO</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>David M Underwood</u>																								
	(Title) <u>EVP & CFO</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>July 2006</u>																									
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																							
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Dave Underwood</u> Telephone Number: <u>309 823-7135</u>																									
Email Address: _____																									

Facility Name & ID Number Heritage Health Streator

0048066 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>130</u>	Skilled (SNF)	<u>130</u>	<u>47,580</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>130</u>	TOTALS	<u>130</u>	<u>47,580</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,967</u>	<u>14,157</u>	<u>5,756</u>	<u>41,880</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,967</u>	<u>14,157</u>	<u>5,756</u>	<u>41,880</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.02%

D. How many bed-hold days during this year were paid by the Department? 0 (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)

None

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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 7/2006

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified _____ and days of care provided 5,756

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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.

Facility Name & ID Number **Heritage Health Streator** # **0048066** Report Period Beginning: **01/01/16** Ending: **12/31/16**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	555,402	17,593		572,995		572,995	6,800	579,795			1
2	Food Purchase		109,585		109,585		109,585		109,585			2
3	Housekeeping	159,466	80,074		239,540		239,540	49	239,589			3
4	Laundry	90,939	20,961		111,900		111,900		111,900			4
5	Heat and Other Utilities			144,955	144,955		144,955	2,113	147,068			5
6	Maintenance	86,763	71,817	98,504	257,084		257,084	28,453	285,537			6
7	Other (specify):*											7
8	TOTAL General Services	892,570	300,030	243,459	1,436,059		1,436,059	37,415	1,473,474			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	3,037,689	225,165	10,303	3,273,157		3,273,157	(40,008)	3,233,149			10
10a	Therapy		1,023,071	46,540	1,069,611	(1,068,664)	947		947			10a
11	Activities	73,997	5,697		79,694		79,694		79,694			11
12	Social Services	46,085		4,227	50,312		50,312		50,312			12
13	CNA Training							1,675	1,675			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,157,771	1,253,933	63,470	4,475,174	(1,068,664)	3,406,510	(38,333)	3,368,177			16
	C. General Administration											
17	Administrative	110,000			110,000		110,000		110,000			17
18	Directors Fees											18
19	Professional Services			430,241	430,241		430,241	(401,314)	28,927			19
20	Dues, Fees, Subscriptions & Promotions			335,134	335,134	(290,643)	44,491	(7,665)	36,826			20
21	Clerical & General Office Expenses	268,466	19,118	9,357	296,941		296,941	397,111	694,052			21
22	Employee Benefits & Payroll Taxes			752,892	752,892		752,892	53,593	806,485			22
23	Inservice Training & Education			10,359	10,359		10,359	1,643	12,002			23
24	Travel and Seminar			11,191	11,191		11,191	(6,192)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,038	58,038		58,038	22,482	80,520			26
27	Other (specify):*			138,833	138,833		138,833	(138,833)				27
28	TOTAL General Administration	378,466	19,118	1,746,045	2,143,629	(290,643)	1,852,986	(79,175)	1,773,811			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,428,807	1,573,081	2,052,974	8,054,862	(1,359,307)	6,695,555	(80,093)	6,615,462			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							309,142	309,142			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			59,019	59,019		59,019	86,273	145,292			32
33	Real Estate Taxes							63,739	63,739			33
34	Rent-Facility & Grounds			569,400	569,400		569,400	(561,369)	8,031			34
35	Rent-Equipment & Vehicles			32,884	32,884		32,884	12,104	44,988			35
36	Other (specify):*											36
37	TOTAL Ownership			661,303	661,303		661,303	(90,111)	571,192			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			889,959	889,959	1,068,664	1,958,623	(276,361)	1,682,262			39
40	Barber and Beauty Shops		954	16,452	17,406		17,406		17,406			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					290,643	290,643		290,643			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		954	906,411	907,365	1,359,307	2,266,672	(276,361)	1,990,311			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,428,807	1,574,035	3,620,688	9,623,530		9,623,530	(446,565)	9,176,965			45

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

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 Refer- ence	3 BHF 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	(847)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(14,675)			19
20	Contributions	(1,549)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,102)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(137,284)			24
25	Fund Raising, Advertising and Promotional	(20,644)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (183,101)		\$	30

BHF 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)	(263,464)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (263,464)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (446,565)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		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		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20			27	20
21				21
22		(8,102)	19	22
23				23
24		(137,284)	27	24
25		(20,644)	20	25
26				26
27		(1,549)	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	(167,579)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	6,800	0	0	0	0	0	0	0	0	6,800	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	49	0	0	0	0	0	0	0	0	49	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,113	0	0	0	0	0	0	0	0	2,113	5
6	Maintenance	0	0	28,453	0	0	0	0	0	0	0	0	28,453	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	37,415	0	0	0	0	0	0	0	0	37,415	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	(40,425)	417	0	0	0	0	0	0	0	0	(40,008)	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	CNA Training	0	0	1,675	0	0	0	0	0	0	0	0	1,675	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	(40,425)	2,092	0	0	0	0	0	0	0	0	(38,333)	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	(8,102)	(419,284)	26,072	0	0	0	0	0	0	0	0	(401,314)	19
20	Fees, Subscriptions & Promotions	(20,644)	0	12,979	0	0	0	0	0	0	0	0	(7,665)	20
21	Clerical & General Office Expenses	0	0	397,111	0	0	0	0	0	0	0	0	397,111	21
22	Employee Benefits & Payroll Taxes	0	0	53,593	0	0	0	0	0	0	0	0	53,593	22
23	Inservice Training & Education	0	0	1,643	0	0	0	0	0	0	0	0	1,643	23
24	Travel and Seminar	(14,675)	0	8,483	0	0	0	0	0	0	0	0	(6,192)	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	22,482	0	0	0	0	0	0	0	0	22,482	26
27	Other (specify):*	(138,833)	0	0	0	0	0	0	0	0	0	0	(138,833)	27
28	TOTAL General Administration	(182,254)	(419,284)	522,363	0	0	0	0	0	0	0	0	(79,175)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(182,254)	(459,709)	561,870	0	0	0	0	0	0	0	0	(80,093)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	272,167	0	36,975	0	0	0	0	0	0	0	309,142	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(847)	86,723	0	397	0	0	0	0	0	0	0	86,273	32
33	Real Estate Taxes	0	63,739	0	0	0	0	0	0	0	0	0	63,739	33
34	Rent-Facility & Grounds	0	(569,400)	0	8,031	0	0	0	0	0	0	0	(561,369)	34
35	Rent-Equipment & Vehicles	0	0	0	12,104	0	0	0	0	0	0	0	12,104	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(847)	(146,771)	0	57,507	0	0	0	0	0	0	0	(90,111)	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	(276,361)	0	0	0	0	0	0	0	0	0	(276,361)	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	(276,361)	0	0	0	0	0	0	0	0	0	(276,361)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(183,101)	(882,841)	561,870	57,507	0	0	0	0	0	0	0	(446,565)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Heritage Enterprises, Inc.	100	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Adjustment for Related Organiza	\$	GreenTree Pharmacy	0.00%	\$ (40,425)	\$ (40,425)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(276,361)	(276,361)	3
4	V	19	Adjustment for Related Organization	419,284	Heritage Operations Group, LLC	0.00%		(419,284)	4
5	V								5
6	V	34	Adjustment for Related Organization	569,400	Heritage Manor Real Estate, LLC	0.00%		(569,400)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		63,739	63,739	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		82,785	82,785	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		272,167	272,167	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		3,938	3,938	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 988,684			\$ 105,843	\$ * (882,841)	14

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

VII. RELATED PARTIES (continued)

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Operations Group LLC		\$	\$ 6,800	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					49	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					2,113	19
20	V	6	Maintenance					28,453	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					417	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,675	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					0	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					26,072	31
32	V	20	Fees, Subscription, Promotions					12,979	32
33	V	21	Clerical & General Office Expenses					397,111	33
34	V	22	Employee Benefits & Payroll Taxes					53,593	34
35	V	23	Inservice Training & Education					1,643	35
36	V	24	Travel and Seminar					8,483	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					22,482	38
39	Total			\$			\$ 0	\$ * 561,870	39

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

VII. RELATED PARTIES (continued)

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Operations Group LLC		\$	0	15
16	V	30	Depreciation					36,975	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					397	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					8,031	20
21	V	35	Rent-Equipment & Vehicles					12,104	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ * 57,507	39

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

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Sole Member		100.00					\$		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 Heritage Health Streator# 0048066 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 ☒ NO ☐

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

Name of Related Organization

Heritage Operations Group

Street Address

Box 3188

City / State / Zip Code

Bloomington, IL 61701

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	Beds	2,571	26	\$ 134,491	\$ 133,835	130	\$ 6,800	1
2	2	Food Purchase	Beds	2,571	26	0	0	130	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	130	49	3
4	4	Laundry	Beds	2,571	26	0	0	130	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	130	2,113	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	130	28,453	6
7	7	Other	Beds	2,571	26	0	0	130	0	7
8	9	Medical Director	Beds	2,571	26	0	0	130	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	130	417	9
10	11	Activities	Beds	2,571	26	0	0	130	0	10
11	12	Social Service	Beds	2,571	26	0	0	130	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	130	1,675	12
13	14	Program Transportation	Beds	2,571	26	0	0	130	0	13
14	15	Other	Beds	2,571	26	0	0	130	0	14
15	17	Administrative	Beds	2,571	26	0	0	130	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	130	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	130	26,072	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	130	12,979	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	130	397,111	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	130	53,593	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	130	1,643	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	130	8,483	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	130	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	130	22,482	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 561,870	25

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 ☒ NO ☐

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

Name of Related Organization Heritage Operations Group
Street Address Box 3188
City / State / Zip Code Bloomington, IL 61701
Phone Number ()
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,571	26	\$	\$	130	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		130	36,975	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			130		3
4	32	Interest	Beds	2,571	26	7,851		130	397	4
5	33	Real Estate Taxes	Beds	2,571	26			130		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		130	8,031	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		130	12,104	7
8	36	Other	Beds	2,571	26			130		8
9	38	Medically Nec Transportation	Beds	2,571	26			130		9
10	39	Ancillary Service Centers	Beds	2,571	26			130		10
11	40	Barber and Beauty Shops	Beds	2,571	26			130		11
12	41	Coffee and Gift Shops	Beds	2,571	26			130		12
13	42	Other	Beds	2,571	26			130		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,137,301	\$		\$ 57,507	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank of America		x	Mortgage			\$					\$ 82,785	1
2	Bank of America		x	Loan Fee Amortization								3,938	2
3													3
4													4
5													5
	Working Capital												
6	Bank of America		x	Working Capital								59,019	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 145,742	9
	B. Non-Facility Related*												
10	Interest Income											(847)	10
11													11
12	Allocated Corporate											397	12
13													13
14	TOTAL Non-Facility Related						\$					(450)	14
15	TOTALS (line 9+line14)						\$					145,292	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$63,739	2
3. Under or (over) accrual (line 2 minus line 1).				\$63,739	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$63,739	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	64,367	8	
		2012	61,277	9	
		2013	64,107	10	
		2014	63,649	11	
		2015		12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME Heritage Health Streator COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048066

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

PLEASE NOTE: *Payment information from the Internet* or otherwise is **not considered acceptable tax bill documentation**. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

A. Square Feet:

39,770

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Evergreen Place-Streator - (53) unit supportive living facility - grounds are adjacent but separate.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	3

Facility Name & ID Number Heritage Health Streator

0048066

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	130				\$ 348,848	\$		\$	\$	4
5					440,122					5
6					2,594,839					6
7										7
8										8
	Improvement Type**									
9										9
10										10
11	1980 Improvements		1980		12,172					11
12	1981 Improvements		1981		13,748					12
13	1982 Improvements		1982		18,366					13
14	1983 Improvements		1983		9,250					14
15	1984 Improvements		1984		1,329					15
16	1985 Improvements		1985		4,100					16
17	1986 Improvements		1986		57,336					17
18	1988 Improvements		1987		6,225					18
19	1989 Improvements		1988		48,818					19
20	1990 Improvements		1989		22,687					20
21	1991 Improvements		1990		31,584					21
22	1992 Improvements		1991		3,560					22
23	1993 Improvements		1992		19,172					23
24	1994 Improvements		1993		23,135					24
25	1995 Improvements		1994		22,036					25
26	BOILER		1995		39,228					26
27	EXHAUST HOOD		1996		3,910					27
28										28
29										29
30										30
31										31
32										32
33	C/O Allocation					36,975		36,975		33
34	Book Depreciation					201,463		201,463		34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health Streator

0048066

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Interior Rehab---Facility	1997	\$ 286,974	\$		\$	\$	\$	37
38 Roof	1997	5,232						38
39 Sprinkler System	1997	9,530						39
40 Code Alert	1997	1,879						40
41								41
42 Code Alert	1998	2,000						42
43 Bathroom Door	1998	656						43
44 Interior Rehab	1998	11,815						44
45								45
46 Door Alarms	1999	3,675						46
47								47
48 Water Heater	2000	4,114						48
49 Exhaust Fans	2000	931						49
50 Booster Heater -- Water Heater	2000	1,465						50
51								51
52 Professional Fees---Building Renovation	2001	27,964						52
53 Sprinkler Replacement	2001	4,955						53
54 AC Unit with Installation	2001	4,372						54
55 Exterior Painting	2001	6,545						55
56 Code Alert System	2001	4,592						56
57								57
58 Roof	2002	48,840						58
59 Sewer line	2002	20,615						59
60 Condensing Unit	2002	1,213						60
61								61
62 Exterior Door	2003	6,556						62
63 Exit Lights	2003	1,013						63
64 Heating Pump	2003	1,746						64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 4,177,147	\$ 238,438		\$ 238,438	\$	\$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Health Streator

0048066

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,177,147	\$ 238,438		\$ 238,438	\$	\$	1
2	Doors	2004	1,386						2
3	A/C	2004	5,061						3
4	PVC kickplate	2004	2,859						4
5	Disposal	2004	1,175						5
6									6
7	Roof	2005	54,596						7
8	A/C Condensing Unit	2005	5,800						8
9	Window Replacement	2005	51,893						9
10	Water Main	2005	1,706						10
11									11
12									12
13	Roof	2006	19,500						13
14	A/C Replacement	2006	1,974						14
15	Boiler	2006	58,327						15
16	Landscapping	2006	5,398						16
17									17
18	Nurse's station	2007	9,580						18
19	Nurse call system	2007	96,193						19
20	Wireless network	2007	26,272						20
21	Corridor Paint and floors	2007	37,819						21
22	A/C	2007	23,747						22
23	Wander guard	2007	4,177						23
24	Garage --Construction of new Maintenance Garage	2007	42,453						24
25	Professional Fee -- remodel	2007	1,286						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,628,349	\$ 238,438		\$ 238,438	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Health Streator

0048066

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,628,349	\$ 238,438		\$ 238,438	\$	\$	1
2	Landscaping	2008	22,238						2
3	Garage --Construction of new Maintenance Garage	2008	9,644						3
4	South Wing Windows	2008	63,040						4
5	Air Handler	2008	10,301						5
6	Redo North Nurses Station	2008	8,101						6
7									7
8	Wireless Network	2009	4,035						8
9	South Dining Room Electric	2009	2,752						9
10	Corridor Doors	2009	22,230						10
11									11
12	Lennox condensor	2010	6,864						12
13	Walkin Cooler	2010	4,313						13
14	Nurse Call System	2010	6,594						14
15	Wood Blinds	2010	2,914						15
16									16
17									17
18	Trane Air Handler	2011	58,281						18
19	Trane Rooftop Unit	2011	3,017						19
20	Gas Water Heater	2011	4,352						20
21	Air Condition Coils	2011	7,904						21
22	Water Heater	2011	4,352						22
23	Wiring & Installation	2011	7,546						23
24	Sealer & Coating	2011	8,985						24
25	Sign	2011	2,650						25
26									26
27	Goodman Condensing Unit	2012	9,494						27
28	Flooring Replacement	2012	176,220						28
29	GFI & Receptical	2012	4,158						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,078,334	\$ 238,438		\$ 238,438	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Health Streator

0048066

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,078,334	\$ 238,438		\$ 238,438	\$	\$	1
2	Lighting Retrofit-Facility wide replacement of ballasts and bulbs	2013	8,250						2
3	Renovation of rooms & hallways in corridors 300 & 400	2013	229,287						3
4	(Removal and replacement of flooring and cabinets; painting)	2014	87,266						4
5									5
6	Renovation of rooms & hallways in corridors 100 & 200								6
7	(Removal and replacement of flooring and cabinets; painting)	2014	235,862						7
8	Water Heater Replacement	2014	17,378						8
9	Install Electric Door	2014	6,242						9
10	Parking Lot Fill and Seal	2014	6,863						10
11									11
12	Installed (2) new hot water heater expansion tanks	2015	3,785						12
13	Install electric heat in air handlers - NE and NW wings	2015	9,295						13
14	Completion of 2014 renovation to corridors 100&200 -	2015	3,650						14
15	asbestos abatement								15
16	Replace (4) wood doors	2015	3,440						16
17	Flooring replacement - Rec Room	2015	5,334						17
18	Nurse call system upgrade - telephonic and electrical upgrades	2015	33,961						18
19									19
20	No 2016 Improvements								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	TOTAL (lines 1 thru 33)		\$ 5,728,947	\$ 238,438		\$ 238,438	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$ 63,326	\$ 63,326	\$		\$	71
72	Current Year Purchases	17,113						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 17,113	\$ 63,326	\$ 63,326	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2017 Dodge Grand SW	2016	\$ 43,540	\$ 1,555	\$ 1,555	\$		\$	76
77		2009 Turtletop Bus	2008	40,760	5,823	5,823				77
78										78
79										79
80	TOTALS			\$ 84,300	\$ 7,378	\$ 7,378	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,880,360	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 309,142	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 309,142	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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?
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy:

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$32,884Description:Supplies, copiers and televisions
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 455,068	\$		\$ 455,068	1
2	Licensed Speech and Language Development Therapist		hrs			53,644			53,644	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			381,247	947		382,194	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				1,022,124		1,022,124	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					46,540			46,540	13
14	TOTAL			\$		\$ 936,499	\$ 1,023,071		\$ 1,959,570	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 13,385	\$	1
2	Cash-Patient Deposits	9,647		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,284,628		3
4	Supply Inventory (priced at)	27,346		4
5	Short-Term Investments			5
6	Prepaid Insurance	42,855		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(382,361)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,995,500	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,995,500	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 285,150	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,647		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	354,435		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,522		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	37,373		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 698,127	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 698,127	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,297,373	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,995,500	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 902,564	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 902,564	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	394,809	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 394,809	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,297,373	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Streator

0048066

Report Period Beginning: 01/01/16

Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,011,807	1
2	Discounts and Allowances for all Levels	(4,016,190)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,995,617	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,075,499	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,075,499	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,796	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,881,953	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	44,627	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,946,376	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	847	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 847	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,018,339	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,436,059	31
32	Health Care	4,475,174	32
33	General Administration	2,143,629	33
	B. Capital Expense		
34	Ownership	661,303	34
	C. Ancillary Expense		
35	Special Cost Centers	907,365	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,623,530	40
41	Income before Income Taxes (line 30 minus line 40)**	394,809	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 394,809	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,783	1,877	\$ 73,358	\$ 39.08	1
2	Assistant Director of Nursing	1,739	1,831	60,851	33.23	2
3	Registered Nurses	23,041	24,254	780,242	32.17	3
4	Licensed Practical Nurses	18,612	19,592	556,976	28.43	4
5	CNAs & Orderlies	91,339	96,146	1,441,886	15.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,890	4,095	124,376	30.37	8
9	Activity Director					9
10	Activity Assistants	4,906	5,164	73,997	14.33	10
11	Social Service Workers	1,872	1,971	46,085	23.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	47,432	49,929	555,402	11.12	15
16	Dishwashers					16
17	Maintenance Workers	4,838	5,093	86,763	17.04	17
18	Housekeepers	13,859	14,588	159,466	10.93	18
19	Laundry	7,404	7,794	90,939	11.67	19
20	Administrator	1,984	2,088	110,000	52.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,487	13,144	268,466	20.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	235,186	247,566	\$ 4,428,807 *	\$ 17.89	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		2,400		36
37	Medical Records Consultant		353		37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,735		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,815		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,303		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Heritage Health Streator

0048066

Report Period Beginning:

01/01/16

Ending:

12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Bonnie Bradley			\$ 110,000	Workers' Compensation Insurance	\$ 73,269	IDPH License Fee	\$	
				Unemployment Compensation Insurance	47,974	Advertising: Employee Recruitment	8,146	
				FICA Taxes	338,804	Health Care Worker Background Check		
				Employee Health Insurance	251,429	(Indicate # of checks performed)	5,665	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
						PR	10,653	
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits	41,416	Dues & Subscriptions	11,456	
(List each licensed administrator separately.)			\$ 110,000	Central Office Allocation	53,593	License & Fees	5,115	
B. Administrative - Other						Central Office Allocation	12,979	
Description			Amount			Less: Public Relations Expense	(10,653)	
			\$			Non-allowable advertising	(6,535)	
						Yellow page advertising (		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 806,485	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 36,826	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$
Heritage Operations Group			\$ 419,283					
ADP	Payroll Tax Processing		1,557					
Tango Inc	ACA Compliance		1,299				In-State Travel	
								7,645
								27
							Seminar Expense	3,519
								(6,192)
Legal adj to Zero			8,102				Entertainment Expense (	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 430,241	TOTAL		\$	TOTAL	\$ 4,999
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Health Streator	STATE OF ILLINOIS # 0048066	Report Period Beginning: 01/01/16	Ending: 12/31/16
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 290,643
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 236,078

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sulaski & Webb

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees

Heritage Manor Streator
HFS ID# 203902216001
HFS Cost Report - December 31, 2016
Schedule V - Column 5 Reclassifications

		<u>Add (Subtract)</u>
<u>Reclassification of Provider Participation Fees</u>		
Provider Participation Fee - \$1.50	Line 20, Col 3	(71,370)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(219,273)
		<u>(290,643)</u>
		<u>(290,643)</u>
Provider Participation Fee	Line 42	<u>290,643</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(1,022,124)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(46,540)
		<u>(1,068,664)</u>
		<u>(1,068,664)</u>
Ancillary Service Centers	Line 39	<u>1,068,664</u>