

		FOR BHF USE			

LL2

Supportive Living Facility

2021

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2021)

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: 1000060

Facility Name: Prairie Crossing

Address: 407 W Comanche Ave Shabbona 60550

County: DeKalb

Telephone Number: (815) 824-8480 Fax # (815) 824-2412

Federal Employer ID Number: _____

Date Current Owners were Certified: 12/01/2012

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
 ☒ PROPRIETARY
 ☐ GOVERNMENTAL

☐ Charitable Corp.
 ☐ Individual
 ☐ State
 ☐ Partnership
 ☐ County
 ☐ Corporation
 ☐ Other
 ☒ "Sub-S" Corp.
 ☒ Limited Liability Co.
 ☐ Trust
 ☐ Other

IRS Exemption Code _____

In the event there are further questions about this report, please contact:

Name: Amanda Springborn Telephone Number: (314) 925-3838

Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2021 to 12/31/2021 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date) _____
 (Type or Print Name) _____
 (Title) _____

Paid Preparer

(Signed) _____ (Date) _____
 (Print Name and Title) _____
 (Firm Name & Address) RSM US LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
 (Telephone) (847) 517-7070 Fax (847) 517-7067

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

HFS 3745C (N-4-05)

IL478-2471

Facility Name Prairie Crossing

Report Period Beginning:

01/01/2021

Ending: 12/31/2021

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units

N/A

	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	29	Single Unit Apartment	29	10,585	1
2	7	Double Unit Apartment	7	2,555	2
3		Other			3
4	36	TOTALS	36	13,140	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	7,571	1,638	130	9,339	5
6	Double Unit	400	2,417		2,817	6
7	Other					7
8	TOTALS	7,971	4,055	130	12,156	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.51%

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

N/A

Also, indicate the number of unpaid bed-hold days the SLF

had during this year. N/A (Do not include bed-hold days in Section B.)

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES

☒

NO

☐

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES

☐

NO

☒

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

None

H. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

I. Is your fiscal year identical to your tax year?

☒

YES

☐

NO

Tax Year:

12/31/2021

Fiscal Year:

12/31/2021

* 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 principal?

N/A

If no, explain.

N/A

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 principal?

N/A

If no, explain.

N/A

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 principal?

N/A

If no, explain.

N/A

STATE OF ILLINOIS

Page 3

Facility Name: Prairie Crossing

Report Period Beginning:

01/01/2021

Ending:

12/31/2021

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	116,419	93,073	2,886	212,378		212,378	1
2	Housekeeping, Laundry and Maintenance	24,461	25,826	6,939	57,226		57,226	2
3	Heat and Other Utilities			34,646	34,646		34,646	3
4	Other (specify):							4
5	TOTAL General Services	140,880	118,899	44,471	304,250		304,250	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	287,699	927	500	289,126		289,126	6
7	Activities and Social Services	28,895	17,660		46,555		46,555	7
8	Other (specify): Covid Related Nursing Expenses					(116,442)	(116,442)	8
9	TOTAL Health Care and Programs	316,594	18,587	500	335,681	(116,442)	219,239	9
	C. General Administration							
10	Administrative and Clerical	64,133		107,831	171,964	(7,225)	164,739	10
11	Marketing Materials, Promotions and Advertising			4,510	4,510	(4,510)		11
12	Employee Benefits and Payroll Taxes			58,826	58,826		58,826	12
13	Insurance-Property, Liability and Malpractice					54,966	54,966	13
14	Other (specify):							14
15	TOTAL General Administration	64,133		171,167	235,300	43,231	278,531	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	521,607	137,486	216,138	875,231	(73,212)	802,020	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			11,608	11,608	248,235	259,843	17
18	Interest			34	34	96,322	96,356	18
19	Real Estate Taxes					29,053	29,053	19
20	Rent -- Facility and Grounds			240,000	240,000	(240,000)		20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			251,642	251,642	133,610	385,252	23
24	GRAND TOTAL (Sum of lines 16 and 23)	521,607	137,486	467,780	1,126,873	60,399	1,187,272	24

Facility Name: **Prairie Crossing**

Report Period Beginning: **01/01/2021** Ending: **12/31/2021**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.00	\$ 32.36	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.01	15.11	3
4	Activity Director & Assistants	1.01	13.81	4
5	Social Service Workers			5
6	Head Cook	0.95	16.86	6
7	Cook Helpers/Assistants	3.34	11.96	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1.08	10.86	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	1.08	28.65	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	15.47	\$	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	2.00
See Schedule 4A			

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	See Schedule 4A			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	N/A	\$ 1
2		\$ 2
Total		\$ 3

OTHER RELATED BUSINESS ENTITIES		
Name	3	City 4
See Schedule 4A		

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).

Prairie Crossing Assisted Living, LLC
12/31/2021
Schedule 4A

V.I.A

Owners:

<u>Name</u>	<u>Ownership Interest</u>	<u>Avg. Hours per Work Week</u>	<u>Compensation</u>
Moshe Herman	72.50%	10	N/A
Stuart Milstein	4.50%	N/A	N/A
Ari Milstein	4.50%	N/A	N/A
Elana Minkove	4.50%	N/A	N/A
Robin Krystal	4.00%	N/A	N/A
David Zuckerman	10.00%	N/A	N/A
TOTAL	100.00%		

VII. A

Related Organizations: Related SLF's & Health Care Businesses

<u>In State</u>	<u>City</u>
Cahokia Nursing and Rehab, Inc.	Cahokia
Caseyville Nursing and Rehab, Inc.	Caseyville
Franklin Grove Living & Rehabilitation, LLC	Franklin Grove
Oregon Living & Rehabilitation, LLC	Oregon
Prairie Crossing Living & Rehab Center, LLC	Shabbona
Tower Hill Rehab LLC	South Elgin

<u>Out of State</u>	
Beauvais Manor Healthcare and Rehab	St. Louis, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO
Rancho Manor Healthcare and Rehab	Florissant, MO
Rosewood Health & Rehab	Independence, MO
Seasons Care Center	Kansas City, MO
Carriage Square Living & Rehab	St. Joseph, MO

Other Related Business Entities

<u>Name</u>	<u>City</u>	<u>Type of Business</u>
Groves Community Hospice	Independence, MO	Hospice
Forest View Senior Residences	Independence, MO	Independent Living
White Oak Living Center	Independence, MO	Residential Care
Seasons Day Services Program, LLC	Kansas City, MO	Adult Day Care
Cahokia Building LLC	Cahokia	Real Estate
Caseyville Property LLC	Caseyville	Real Estate
Green Acres Property	Amboy	Real Estate
FOM Property LLC	Franklin Grove	Real Estate
Oregon Property LLC	Oregon	Real Estate
Prairie Crossing Property LLC	Shabbona	Real Estate
Tower Hill Property, LLC	South Elgin	Real Estate
Beauvais Manor Property, LLC	St. Louis, MO	Real Estate
Hillside Manor Real Estate & Development	St. Louis, MO	Real Estate
Rancho Manor Property, LLC	Florissant, MO	Real Estate
The Groves & Rest Haven Property, LLC	Independence, MO	Real Estate
Seasons Property, LLC	Kansas City, MO	Real Estate
Carriage Square Property LLC	St. Joseph, MO	Real Estate

Facility Name: **Prairie Crossing**

Report Period Beginning:

01/01/2021

Ending:

12/31/2021

VIII. OWNERSHIP COSTS

A. Purchase price of land 33,632 Year land was acquired 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	36		2006	2006	\$ 2,605,419	\$	28	\$ 95,156	\$ 95,156	\$ 1,303,794	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Laundry Room			2007	12,716		28	462	462	6,796	6
7	Carpet			2007	4,998		28	182	182	2,571	7
8	Check valve			2008	5,435		28	198	198	2,599	8
9	Fence			2008	2,434		15	162	162	1,895	9
10	Elevator Motor			2009	8,133		28	296	296	3,688	10
11	Carpet			2009	2,798		28	102	102	1,313	11
12	Build Office Space in Lower Level			2014	12,380	411	28	450	39	2,794	12
13	Install handrails in cooridors			2015	11,787	393	28	429	36	2,359	13
14	Replace Flooring in Dining Room			2015	4,654		5	465	465	5,119	14
15	Replace Governor in Elevator			2016	12,457	416	28	453	37	2,491	15
16	See 5A				63,797			6,725	6,725	18,886	16
17	TOTAL (lines 1 thru 16)				\$ 2,747,008	\$ 1,220		\$ 105,080	\$ 103,860	\$ 1,354,305	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 1,183,789	\$	\$ 154,763	154,763	5-7	\$ 1,115,952	18
19	Vehicles	15,138					15,138	19
20	TOTAL (lines 18 and 19)	\$ 1,198,927	\$	\$ 154,763	154,763		\$ 1,131,090	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	N/A	\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Prairie Crossing Assisted Living, LLC
12/31/2020
5A

Improvement Type	Year Constructed	Cost	Book Dep.	Years in Life	S.L. Dep.	Adjustments	Acc. Dep.
Carpet	2018	10,395		5	2,079	2,079	6,757
PTAC units	2018	8,142		5	1,628	1,628	5,405
Kitchen Floor	2019	25,250		15	1,683	1,683	4,209
Sidewalk/Blacktop	2019	7,730		15	515	515	1,289
Gas Filters	2020	5,100		15	340	340	510
Parking lot	2020	7,180		15	479	479	718
		63,797			6,725	6,725	18,887

Facility Name: Prairie Crossing Report Period Beginning: 01/01/2021 Ending: 2/31/2021

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*	
3	Original Building	N/A		/ /	\$ N/A			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 \$ N/A

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1	Capital One		X	Mortgage	1/1/16	\$ 2,706,120	\$ 2,460,406	2/1/51	0.0371	\$ 96,453	1
2											2
3											3
	Working Capital										
4	SBA-PPP Loan		X	Payroll & Oper Exp	4/24/20	116,443		4/24/22	0.0100		4
5											5
6	Security Deposit Interest									34	6
7	TOTAL Facility Related					\$ 2,822,563	\$ 2,460,406			\$ 96,487	7
	B. Non-Facility Related										
8						Nonallowable Interest Expense				(131)	8
9											9
10	TOTALS (lines 7, 8 and 9)					\$ 2,822,563	\$ 2,460,406			\$ 96,356	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: **Prairie Crossing**Report Period Beginning: **01/01/2021**Ending: **12/31/2021****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2021**

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 588,993	\$ 611,215	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	23,431	23,431	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,575	23,889	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		65,507	8
9	Other(specify): See Schedule 7A	223,488	379,727	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 840,487	\$ 1,103,768	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		33,632	13
14	Buildings, at Historical Cost		2,605,419	14
15	Leasehold Improvements, at Historical Cost	41,278	141,589	15
16	Equipment, at Historical Cost	44,806	1,198,928	16
17	Accumulated Depreciation (book methods)	(57,180)	(2,485,395)	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): See Sch 7A	523,794	914,602	22
23	Other(specify): Mortgage Costs		54,041	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 552,698	\$ 2,462,816	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,393,185	\$ 3,566,584	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 10,989	\$ 10,989	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,384	9,384	30
31	Accrued Taxes Payable	30,774	59,874	31
32	Accrued Interest Payable		7,607	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Schedule 7A	45,103	39,014	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 96,250	\$ 126,868	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		2,460,406	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)	\$	\$ 2,460,406	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 96,250	\$ 2,587,274	45
46	TOTAL EQUITY	\$ 1,296,935	\$ 979,310	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,393,185	\$ 3,566,584	47

*(See instructions.)

Schedule 7A

XI. Balance Sheet
B. Long-Term Assets
Line 9: Other current assets

Description	After	
	Operating	Consolidation
1500 Escrow - Replacement Reserve	-	81,998
1501 Escrow - Insurance	-	47,377
1502 Escrow - Mip	-	14,253
1503 Escrow - Real Estate Taxes	-	12,610
3030 Short Term Loan Exchange	223,488	223,488
Total Other Current Assets	223,488	379,727
	-	-

XI. Balance Sheet
B. Long-Term Assets
Line 22: Other long-term assets

Description	After	
	Operating	Consolidation
8811 Due/From Slf Building Partnshp	523,794	314,602
6040.02 Goodwill-Pca	-	600,000
Total Other Long-Term Assets	523,794	914,602
	-	-

XI. Balance Sheet
C. Current Liabilities
Line 35: Other current Liabilities

Description	After	
	Operating	Consolidation
7055 Insurance Premiums Payable	-	-
7111 Fica Withholding	687	687
7145 Acc. Retirement (From P/R)	66	66
7310 Accrued Expenses	44,350	44,350
7610 Short Term Loan Exchange	-	-
8812 Due To/From Pca	-	(6,089)
Total Other Current Liabilities	45,103	39,014
	-	-

Facility Name: Prairie Crossing

Report Period Beginning: 01/01/2021

Ending:

12/31/2021

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	\$ 1,532,770	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,532,770	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	8,357	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 8,357	14
	D. Other Revenue (specify):		
15	Misc. Income	16,313	15
16	Covid Revenue	116,442	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 132,755	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,673,882	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	304,250	19
20	Health Care/ Personal Care	335,681	20
21	General Administration	235,300	21
	B. Capital Expense		
22	Ownership	251,642	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)	\$ 1,126,873	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 547,009	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 547,009	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,038,435	32
33	Private Pay - Net Inpatient Revenue	494,335	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,532,770	37