

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2016  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2016)**

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.

<p><b>I. Facility ID Number:</b> <u>1000036</u></p> <p><b>Facility Name:</b> <u>Coles Supportive Living</u></p> <hr/> <p><b>Address:</b> <u>7419 South Exchange</u> <u>Chicago</u> <u>60649</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> ( <u>(773) 721-6600</u> Fax # _____</p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>1/1/2016</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 282 - 6300</u></p> <p><b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input checked="" type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2016</u> to <u>12/31/2016</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td>                 (Signed) _____                  (Type or Print Name) _____                  (Title) _____             </td> </tr> <tr> <td style="width:20%; vertical-align: top;"> <b>Paid Preparer</b> </td> <td>                 (Signed) _____ *                  * Subject to the attached Accountants Consulting Report                  (Print Name and Title) _____                  (Firm Name &amp; Address) <u>Marcum LLP</u>  <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>                  (Telephone) <u>(847) 282-6300</u> Fax <u>(847) 282-6301</u> </td> </tr> </table> <p align="right">                 (Date) _____                  (Date) _____             </p> <p align="right"> <b>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</b> </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) _____ (Title) _____	<b>Paid Preparer</b>	(Signed) _____ * * Subject to the attached Accountants Consulting Report (Print Name and Title) _____ (Firm Name & Address) <u>Marcum LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input type="checkbox"/> "Sub-S" Corp.	_____																											
	<input checked="" type="checkbox"/> Limited Liability Co.	_____																											
	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) _____ (Title) _____																												
<b>Paid Preparer</b>	(Signed) _____ * * Subject to the attached Accountants Consulting Report (Print Name and Title) _____ (Firm Name & Address) <u>Marcum LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax <u>(847) 282-6301</u>																												

Facility Name Coles Supportive Living

Report Period Beginning: 1/1/2016 Ending: 12/31/2016

**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	129	Single Unit Apartment	129	47,214	1
2	10	Double Unit Apartment	10	3,660	2
3		Other			3
4	139	TOTALS	139	50,874	4

**B. Census-For the entire report period.**

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	28,905	795		29,700	5
6	Double Unit					6
7	Other					7
8	TOTALS	28,905	795		29,700	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 58.38%

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

None Also, indicate the number of unpaid bed-hold days the SLF had during this year. None (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: 12/31/16 Fiscal Year: 12/31/16

\* 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? N/A

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? N/A

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? N/A

If no, explain. \_\_\_\_\_

Facility Name: Coles Supportive Living

Report Period Beginning:

1/1/2016

Ending: 12/31/2016

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	184,537	200,691	3,956	389,184		389,184	1
2	Housekeeping, Laundry and Maintenance	143,327	32,608	79,406	255,341	(26,733)	228,608	2
3	Heat and Other Utilities			120,799	120,799	630	121,429	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	327,864	233,299	204,161	765,324	(26,103)	739,221	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	464,532	5,653		470,185	3,667	473,852	6
7	Activities and Social Services	26,897	1,305	2,455	30,657		30,657	7
8	Other (specify):					442	442	8
9	<b>TOTAL Health Care and Programs</b>	491,429	6,958	2,455	500,842	4,109	504,951	9
<b>C. General Administration</b>								
10	Administrative and Clerical	222,664	3,661	207,275	433,600	(99,365)	334,235	10
11	Marketing Materials, Promotions and Advertising	46,502		34,000	80,502	349	80,851	11
12	Employee Benefits and Payroll Taxes			174,315	174,315		174,315	12
13	Insurance-Property, Liability and Malpractice			61,347	61,347		61,347	13
14	Other (specify):					5,541	5,541	14
15	<b>TOTAL General Administration</b>	269,166	3,661	476,937	749,764	(93,475)	656,289	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	1,088,459	243,918	683,553	2,015,930	(115,469)	1,900,461	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation					160,827	160,827	17
18	Interest			2,910	2,910	223,874	226,784	18
19	Real Estate Taxes			95,332	95,332		95,332	19
20	Rent -- Facility and Grounds			469,406	469,406	(464,075)	5,331	20
21	Rent -- Equipment			49	49		49	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			567,697	567,697	(79,374)	488,323	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	1,088,459	243,918	1,251,250	2,583,627	(194,843)	2,388,784	24

Report Period Beginning: 1/1/2016  
 Ending: 12/31/2016

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Non-Straight Line Depreciation	\$ (252,202)	17
2	Non-Allowable R&M	(9,522)	2
3	Cable TV	(17,502)	2
4	Bank Charges	(19,656)	10
5	Bad Debts	(2,795)	10
6	Meals & Entertainment	(17)	10
7	Misc Revenue	(150)	10
9	BUILDING COMPANY		9
10	Interest Income	(30)	18
11	Interest Expense	223,904	18
12	Depreciation and Amortization	413,629	17
13	Res	(469,406)	20
15	MANAGEMENT OFFICE ALLOCATION		15
16	Housekeeping/Maint/Laundry	291	2
17	Utilities	636	3
18	Health Care/Personal Care	3,667	6
19	Health Care Emp Ben/Payroll Taxes	442	8
20	Administrative and General	80,176	10
21	Advertising and Marketing	349	11
22	Admin Emp Benefits & Payroll Taxes	5,541	14
23	Building Rental	5,331	20
24	Management Office Allocation	(156,923)	10
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49			49
50			50
51			51
52			52
53			53
54			54
55			55
56			56
57			57
58			58
59			59
60			60
61			61
62			62
63			63
64			64
65			65
66			66
67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	<b>Total</b>	(194,843)	101

Facility Name: Coles Supportive Living

Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.70	\$ 25.77	1
2	Licensed Practical Nurses	4.11	21.55	2
3	Certified Nurse Assistants	11.17	10.45	3
4	Activity Director & Assistants	1.13	11.48	4
5	Social Service Workers	-		5
6	Head Cook	0.82	14.75	6
7	Cook Helpers/Assistants	7.16	10.70	7
8	Dishwashers	-		8
9	Maintenance Workers	0.69	13.85	9
10	Housekeepers	5.48	10.82	10
11	Laundry	-		11
12	Managers	-		12
13	Other Administrative	1.50	26.64	13
14	Clerical	5.97	11.23	14
15	Marketing	1.00	22.36	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>39.73</b>	<b>\$ 13.17</b>	<b>17</b>

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	N/A			\$	1
2					2
3					3
4					4
5					5
<b>Total</b>				<b>\$</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

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

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	City
1 Rockford Supportive Living	2 Rockford, IL
Robbins Supportive Living	Robbins, IL
Jackson Park Supportive Living	Chicago, IL

OTHER RELATED BUSINESS ENTITIES

Name	City	Type of Business
3 Grand Lifestyles	4 Skokie, IL	5 Management Co.
Coles IL SLF Realty	Chicago, IL	Building Co.

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: N/A If yes, what is the value of those services? \$ N/A

(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).

Facility Name: Coles Supportive Living

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VIII. OWNERSHIP COSTS

A. Purchase price of land 305,000 Year land was acquired 2016

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	139		2016	2004	\$ 2,458,747	\$ 413,029	35	\$ 70,250	\$ (342,779)	\$ 70,250	1	
2											2	
3											3	
4											4	
5											5	
<b>Improvement Type</b>												
6	Total From Supplemental Page 5's											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)				\$ 2,458,747	\$ 413,029		\$ 70,250	\$ (342,779)	\$ 70,250	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	\$ 896,253	\$	\$ 89,625	89,625	10	\$ 89,625	18
19	Vehicles	9,522		952	952		952	19
20	TOTAL (lines 18 and 19)	\$ 905,775	\$	\$ 90,577	90,577		\$ 90,577	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 & ID Number Coles Supportive Living

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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	
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								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	34

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

Facility Name & ID Number Coles Supportive Living

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$

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

Facility Name & ID Number Coles Supportive Living

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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	
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								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	34

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

Facility Name: Coles Supportive Living

Report Period Beginning: 1/1/2016

Ending: 2/31/2016

**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							3
4	Additions			/ /				4
5				/ /				5
6	Allocated from Grand Lifestyle			/ /	5,331			6
7	TOTAL				\$ 5,331			7

8. Is movable equipment rental included in building rental?  
 YES  NO

9. Rental amount for movable equipment \$ 49

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				
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1	MB Financial		X	Mortgage		\$	5,132,620			\$ 223,904	1
2											2
3											3
	<b>Working Capital</b>										
4	MB Financial		X	Line of Credit	/ /			/ /		2,910	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	5,132,620			\$ 226,814	7
	<b>B. Non-Facility Related</b>										
8	Interest Income		X		/ /			/ /		(30)	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	5,132,620			\$ 226,784	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: Coles Supportive Living

Report Period Beginning: 1/1/2016

Ending:

12/31/2016

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 186,718	\$ 351,240	1
2	Cash-Patient Deposits	10,935	10,935	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	550,424	508,699	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	42,158	62,158	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	13,879	172,626	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 804,114	\$ 1,105,658	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		305,000	13
14	Buildings, at Historical Cost		2,458,747	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		896,253	16
17	Accumulated Depreciation (book methods)		(413,029)	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):		2,440,000	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 5,686,971	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 804,114	\$ 6,792,629	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 58,362	\$ 81,072	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,421	52,421	30
31	Accrued Taxes Payable	113,247	113,247	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36	See Attached	13	13	36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 224,043	\$ 246,753	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable		5,132,620	39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43	See Attached	25,238	25,238	43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 25,238	\$ 5,157,858	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 249,281	\$ 5,404,611	45
46	<b>TOTAL EQUITY</b>	\$ 554,833	\$ 1,388,018	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 804,114	\$ 6,792,629	47

\*(See instructions.)

Facility Name: Coles Supportive Living

Report Period Beginning: 1/1/2016

Ending:

12/31/2016

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

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 3,138,251	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 3,138,251</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
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	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	59	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 59</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15		150	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 150</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 3,138,460</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	765,324	19
20	Health Care/ Personal Care	500,842	20
21	General Administration	749,764	21
<b>B. Capital Expense</b>			
22	Ownership	567,697	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 2,583,627</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 554,833</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 554,833</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 2,208,237	32
33	Private Pay - Net Inpatient Revenue	930,014	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 3,138,251</b>	<b>37</b>