

		FOR BHF USE			

LL2

Supportive Living Facility
2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p>I. Facility ID Number: <u>1000100</u></p> <p>Facility Name: <u>Pinnacle Place</u></p> <hr/> <p>Address: <u>1125 North 5th St</u> <u>Savanna</u> <u>61074</u> Number City Zip Code</p> <p>County: <u>Carroll</u></p> <p>Telephone Number: (<u>815 273-2105</u> Fax # <u>815 778-4503</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>6/30/2008</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" 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>IRS Exemption Code <u>501© 3</u></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 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>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501© 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2016</u> to <u>06/30/2017</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;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Robin Landis</u> (Title) <u>CFO</u></td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Robin Landis</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____																												
<p>In the event there are further questions about this report, please contact: Name: <u>Robin Landis</u> Telephone Number: (<u>815 778-3683</u> Email Address: _____</p>	<p align="center">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</p>																												

Facility Name Pinnacle Place

Report Period Beginning: 7/1/2016 Ending: 06/30/2017

III. STATISTICAL DATA

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

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	19	Single Unit Apartment	19	6,935	1
2	2	Double Unit Apartment	2	730	2
3		Other			3
4	21	TOTALS	21	7,665	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	1,810	4,468		6,278	5
6	Double Unit	369	271		640	6
7	Other					7
8	TOTALS	2,179	4,739		6,918	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.25%

D. Indicate the number of paid bed-hold days the SLF had during this year
22 Also, indicate the number of unpaid bed-hold days the SLF had during this year. _____ **(Do not include bed-hold days in Section B.)**

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

YES NO

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

YES NO

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

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO
 Tax Year: 0630/2017 Fiscal Year: 06/30/2017

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? no If yes, did the facility make all of the required payments of interest and principle? _____
 If no, explain. _____

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? no If yes, did the facility make all of the required payments of interest and principle? _____
 If no, explain. _____

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? no If yes, did the facility make all of the required payments of interest and principle? _____
 If no, explain. _____

Facility Name: Pinnacle Place

Report Period Beginning:

7/1/2016

Ending: 06/30/2017

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	36,742	48,660	2,063	87,465	(317)	87,148	1
2	Housekeeping, Laundry and Maintenance	24,881	7,501	20,367	52,749		52,749	2
3	Heat and Other Utilities			48,932	48,932	(6,201)	42,731	3
4	Other (specify):							4
5	TOTAL General Services	61,623	56,161	71,362	189,146	(6,518)	182,628	5
B. Health Care and Programs								
6	Health Care/ Personal Care	146,211	345		146,556		146,556	6
7	Activities and Social Services							7
8	Other (specify):							8
9	TOTAL Health Care and Programs	146,211	345		146,556		146,556	9
C. General Administration								
10	Administrative and Clerical	38,268	411	76,750	115,429	(1,386)	114,043	10
11	Marketing Materials, Promotions and Advertising			4,498	4,498		4,498	11
12	Employee Benefits and Payroll Taxes			43,655	43,655	944	44,599	12
13	Insurance-Property, Liability and Malpractice			18,013	18,013		18,013	13
14	Other (specify):							14
15	TOTAL General Administration	38,268	411	142,916	181,595	(442)	181,153	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	246,102	56,917	214,278	517,297	(6,960)	510,337	16
Capital Expenses								
D. Ownership								
17	Depreciation			78,639	78,639	1,762	80,401	17
18	Interest			18,633	18,633		18,633	18
19	Real Estate Taxes			9,774	9,774		9,774	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			107,046	107,046	1,762	108,808	23
24	GRAND TOTAL (Sum of lines 16 and 23)	246,102	56,917	321,324	624,343	(5,198)	619,145	24

PINNACLE PLACE
1125 N 5TH ST
SAVANNA IL 61074
FEIN 23-7136038

2017 COST REPORT

SCHEDULE OF RECLASSIFICATION
Page 3, Scheudle IV

	<u>D</u>	<u>C</u>
Line #		
3 Remove resident room portion of cable TV		\$ 6,201
10 Adjustment for related orgs	\$ (4,907)	
10 Employee for other org	\$ 3,521	
12 Organizational costs	\$ 944	
17 Adjust to straightline Depr	\$ 1,762	
1 Remove portion of guest meals		317
	\$ 1,320	\$ 6,518

Facility Name: Pinnacle Place

Report Period Beginning: 7/1/2016

Ending:

06/30/2017

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	5.36	13.10	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1.65	10.73	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers	1.09	10.97	9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.19	15.42	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	9.29	\$ 12.73	17

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	Winning Wheels	100		\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
Total		\$ 3

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
Winning Wheels		Prophetstown	
STRIVE		Prophetstown	
Frontier Hollow		Prophetstown	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
American Health Enterprise		Lyndon		Mgt. Company	

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).

PINNACLE PLACE
 1125 N. 5th St.
 Savanna, IL 61074
 FIN: 23-7136038

2017 Cost Report

SCHEDULE OF RELATED ORGANIZATION COSTS

Page 4, Schedule VII, Question C

Page 3 Line #	Related Organization	Nature of Expense	Cost per General Ledger	Cost to Related Organization	Difference: Adjustment for Related Organization Cost
10	American Health Enterprises 501 6th Ave. W., Lyndon, IL 61261	Administrative contract service	76,750		-76,750
10	American Health Enterprises 501 6th Ave. W., Lyndon, IL 61261	Manager salary		60,662	60,662
10	American Health Enterprises 501 6th Ave. W., Lyndon, IL 61261	Home office salaries		8,270	8,270
12	American Health Enterprises 501 6th Ave. W., Lyndon, IL 61261	Employee benefits		945	945
10	American Health Enterprises 501 6th Ave. W., Lyndon, IL 61261	Home office costs		1,021	1,021
	Total Difference: Adjustment for Related Organization Cost				-5,852

Facility Name: Pinnacle Place

Report Period Beginning:

7/1/2016

Ending:

06/30/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land 40,000 Year land was acquired 1997

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	21		1997		\$ 1,155,267	\$ 42,010	28	\$ 42,010	\$	\$ 848,946	1
2											2
3											3
4											4
5											5
Improvement Type											
6		BUILDING ADDITION	1997		107,843	2,696	40	2,696		52,798	6
7		BUILDING ADDITION	1998		16,500	600	28	600		11,975	7
8		WATER HEATER	2002		3,357	78	39	78		1,535	8
9		SEAL PARKING LOT	2002		6,240	184	15	184		6,240	9
10		CHIMNEY CAPS	2003		984	36	28	36		526	10
11		TUCK POINTING	2003		128,000	4,655	28	4,655		67,685	11
12		REMODEL BATH	2003		24,893	905	28	905		13,088	12
13		ROOF	2003		92,377	3,359	28	3,359		48,008	13
14		CARPET	2006		8,269		7			8,269	14
15		ENTRANCE SIGN	2006		1,621	96	15	96		1,286	15
16		CONTINUED on Pg 5			233,228	13,015		14,777	1,762	153,629	16
17		TOTAL (lines 1 thru 16)			\$ 1,778,579	\$ 67,634		\$ 69,396	\$ 1,762	\$ 1,213,985	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	\$ 142,667	\$ 11,005	\$ 11,005	\$	9	\$ 126,520	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 142,667	\$ 11,005	\$ 11,005	\$		\$ 126,520	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: Pinnacle Place

Report Period Beginning: 1/1/2015

Ending: 6/30/2015

SCHEDULE OF PAGE 5, SCHEDULE VIII, SECTION B, LINE 16

		3	4	5	6	7	8	9	
		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	ASBESTOS REMOVAL	2007	960	57	15	64	7	648	1
2	LOCKS	2008	4,386	259	15	292	33	2,703	2
3	SMOKE DETECTORS	2008	19,522	1,153	15	1,301	148	12,029	3
4	FIRE DOORS	2008	7,843	463	15	523	60	4,833	4
5	FLOORING	2009	700		7		0	700	5
6	WASHERS AND DRYERS	2007	3,685		7		0	3,685	6
7	PLASMA TV	2009	1,050		3		0	1,050	7
8	A/C CONDENSOR	2009	1,020		7		0	1,020	8
9	ICE MACHINE	2009	2,295		7		0	2,295	9
10	WATER HEATER	2009	4,628		7		0	4,628	10
11	PARKING LOT	1997	31,223		15		0	31,223	11
12	REFRIGERATOR	2004	2,799		7		0	2,799	12
13	WATER HEATER	2004	4,214		7		0	4,214	13
14	NURSE CALL SYSTEM	2005	24,971	0	10	0	0	24,971	14
15	ZENITH TV	2005	2,845		7	0	0	2,845	15
16	SLF ASSESSMENT	2008	9,879	583	15	583	0	6,671	16
17	DELL COMPUTER	2008	728		5	0	0	728	17
18	FLOORING	2010	940	0	5	0	0	940	18
19	WHIRLPOOL	2010	8,841	395	7	395	0	8,841	19
20	FLOORING	2010	853	0	5	0	0	853	20
21	AWNING	2010	2,030	120	15	120	0	1,131	21
22	EROSION CONTROL	2010	7,195	425	15	425	0	4,009	22
23	FLOORING	2010	1,467	0	5	0	0	1,467	23
24	FLOORING-DINING ROOM AND FRONT ACTIVITY	2013	5,801	829	7	829	0	2,901	24
25	ROOF REPAIRS AROUND ELEVATOR	2013	12,980	865	15	865	0	3,533	25
26	ELEVATOR REPAIRS	2014	11,464	819	7	1,638	819	4,095	26
27	LOCKS AND KEYS	2014	2,633	376	7	376	0	1,316	27
28	APARTMENT FLOORING	2014	1,622	232	7	232	(0)	811	28
29	APARTMENT FURNACE	2014	1,422	203	7	203	0	694	29
30	APARTMENT FLOORING	2014	1,379	197	7	197	0	624	30
31	AIR CONDITIONER	2014	1,327	174	7	174	0	553	31
32	ELEVATOR REPAIRS	2014	9,171	655	7	655	0	3,275	32
33	APARTMENT FLOORING	2015	2,019	144	7	144	0	721	33
34	APARTMENT FLOORING	2015	1,739	104	7	104	0	601	34
35	REPLACED COMPRESSOR	2015	1,584	104	7	226	122	566	35
36	SNOWBLOWER	2015	917	113	7	131	18	317	36
37	PLOW TRUCK ACCESSORIES	2015	2,063	74	7	294	220	663	37
38	WIRELESS CALL SYSTEM	2015	28,033	3,671	7	4,005	334	7,676	38
39	WATER HEATER	2016	5,000	1,000	5	1,000	0	1,000	
40									
41							0		38
	TOTAL FOR LINE 16 ON PAGE 5		\$ 233,228	\$ 13,015		\$ 14,777	\$ 1,762	\$ 153,629	

xx

Facility Name: Pinnacle Place

Report Period Beginning: 7/1/2016

Ending: 6/30/2017

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: _____

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

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

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

9. Rental amount for movable equipment \$ _____

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	2		3	4	6		7	8	9	
		Related**				Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1	MIDLAND STATES BANK		XX	MORTGAGE	7/27/07	\$ 744,497	\$ 471,362	2/27/28	3.7700	\$ 18,633	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 744,497	\$ 471,362			\$ 18,633	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 744,497	\$ 471,362			\$ 18,633	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: Pinnacle Place

Report Period Beginning: 7/1/2016

Ending:

06/30/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2017

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 447	\$ 447	1
2	Cash-Patient Deposits	3,505	3,505	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	135,323	135,323	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,857	4,857	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,418)	(1,418)	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 142,714	\$ 142,714	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000	40,000	13
14	Buildings, at Historical Cost	1,778,579	1,778,579	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	142,667	142,667	16
17	Accumulated Depreciation (book methods)	(1,340,505)	(1,340,505)	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)	\$ 620,741	\$ 620,741	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 763,455	\$ 763,455	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 21,000	\$ 21,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,452	2,452	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	9,500	9,500	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 32,952	\$ 32,952	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	471,362	471,362	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)	\$ 471,362	\$ 471,362	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 504,314	\$ 504,314	45
46	TOTAL EQUITY	\$ 259,141	\$ 259,141	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 763,455	\$ 763,455	47

*(See instructions.)

Facility Name: Pinnacle Place

Report Period Beginning: 7/1/2016

Ending:

06/30/2017

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

		1	
I. Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 624,849	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 624,849	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services	3,521	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	317	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 3,838	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15	TRANSPORTATION	567	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 567	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 629,254	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	189,146	19
20	Health Care/ Personal Care	146,556	20
21	General Administration	142,916	21
B. Capital Expense			
22	Ownership	107,046	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 585,664	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 43,590	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 43,590	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 266,088	32
33	Private Pay - Net Inpatient Revenue	343,831	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Food Stamps</u>	14,930	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 624,849	37