

		FOR BHF USE			

LL2

Supportive Living Facility

2020

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2020)

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: 1000036

Facility Name: Coles Supportive Living

Address: 7419 South Exchange Chicago 60649

County: Cook

Telephone Number: (773) 721-6600 Fax # _____

Federal Employer ID Number: _____

Date Current Owners were Certified: 5/19/2004

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT

☐ Charitable Corp.
 ☐ Trust

IRS Exemption Code _____

☒ PROPRIETARY

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

☐ GOVERNMENTAL

☐ State
 ☐ County
 ☐ Other

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

Name: Steven N. Lavenda

Telephone Number: (847) - 282- 6300

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 1/1/2020 to 12/31/2020 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) _____

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) 4/27/2021

(Print Name and Title) Steven N. Lavenda, CPA
Partner

(Firm Name & Address) Marcum LLP
Nine Parkway North, Suite 200 Deerfield, IL 60015

(Telephone) (847) 282-6300 Fax (847) 282-6301

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

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	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	37,826	1,239		39,065	5
6	Double Unit					6
7	Other					7
8	TOTALS	37,826	1,239		39,065	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 76.79%

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)

N/A

H. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

* 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. _____

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. _____

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. _____

STATE OF ILLINOIS

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Facility Name: Coles Supportive Living

Report Period Beginning:

1/1/2020

Ending: 12/31/2020

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	215,369	226,554	47,040	488,963		488,963	1
2	Housekeeping, Laundry and Maintenance	178,137	55,614	108,750	342,501	(19,938)	322,563	2
3	Heat and Other Utilities			136,063	136,063	1,815	137,878	3
4	Other (specify):							4
5	TOTAL General Services	393,506	282,168	291,853	967,527	(18,123)	949,404	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	404,598	68,930		473,528		473,528	6
7	Activities and Social Services	32,299	1,835	1,012	35,146		35,146	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	436,897	70,765	1,012	508,674		508,674	9
	C. General Administration							
10	Administrative and Clerical	246,113	4,479	356,821	607,413	(120,591)	486,822	10
11	Marketing Materials, Promotions and Advertising	46,100		11,603	57,703	1,458	59,161	11
12	Employee Benefits and Payroll Taxes			173,759	173,759		173,759	12
13	Insurance-Property, Liability and Malpractice			43,813	43,813	93,384	137,197	13
14	Other (specify):					6,883	6,883	14
15	TOTAL General Administration	292,213	4,479	585,996	882,688	(18,866)	863,822	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,122,616	357,412	878,861	2,358,889	(36,990)	2,321,899	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					185,228	185,228	17
18	Interest					263,070	263,070	18
19	Real Estate Taxes			186,144	186,144		186,144	19
20	Rent -- Facility and Grounds			588,488	588,488	(578,667)	9,821	20
21	Rent -- Equipment			5,676	5,676		5,676	21
22	Other (specify):							22
23	TOTAL Ownership			780,308	780,308	(130,369)	649,939	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,122,616	357,412	1,659,169	3,139,197	(167,359)	2,971,838	24

STATE OF ILLINOIS		Page 3A
Coles Supportive Living		
Report Period Beginning:	1/1/2020	
Ending:	12/31/2020	
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1 Non-Straight Line Depreciation	\$ (46,328)	17 1
2 Misc Revenue	(268)	10 2
3 Interest Income	(7,883)	18 3
4 Bad Debts	(553)	10 4
5 Bank Charges	(5,618)	10 5
6 Cable Service	(9,901)	02 6
7 Use Tax	(119)	10 7
8 Capitalized R&M	(30,743)	02 8
9		9 9
10 BUILDING COMPANY		10 10
11 Rent	(588,488)	20 11
12 Interest Income	(293)	18 12
13 Asset Management Fee	20,109	02 13
14 Interest Expense	271,246	18 14
15 Depreciation	231,563	17 15
16 Insurance	91,405	13 16
17		17 17
18 MANAGEMENT OFFICE ALLOCATION		18 18
19 Housekeeping/Mant/Laundry	596	02 19
20 Utilities	1,815	03 20
21 Administrative and General	137,632	10 21
22 Advertising and Marketing	1,458	11 22
23 Insurance	1,979	13 23
24 Admin Emp Benefits & Payroll Taxes	6,883	14 24
25 Building Rental	9,821	20 25
26 Management Fees	(251,665)	10 26
27		27 27
28		28 28
29		29 29
30		30 30
31		31 31
32		32 32
33		33 33
34		34 34
35		35 35
36		36 36
37		37 37
38		38 38
39		39 39
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90		90 90
91		91 91
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93		93 93
94		94 94
95		95 95
96		96 96
97		97 97
98		98 98
99		99 99
100		100 100
101 Total	(167,359)	101 101

Facility Name: Coles Supportive Living

Report Period Beginning 1/1/2020 Ending: 12/31/2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2.57	\$ 26.37	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	9.74	13.01	3
4	Activity Director & Assistants	0.98	15.90	4
5	Social Service Workers			5
6	Head Cook	2.14	13.85	6
7	Cook Helpers/Assistants	5.32	13.89	7
8	Dishwashers			8
9	Maintenance Workers	0.20	14.37	9
10	Housekeepers	6.07	13.63	10
11	Laundry			11
12	Managers			12
13	Other Administrative	0.97	41.97	13
14	Clerical	4.85	16.01	14
15	Marketing	0.66	33.60	15
16	Other			16
17	Total (lines 1 thru 16)	33.50	\$ 16.11	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
Rockford Supportive Living	Rockford, IL
Robbins Supportive Living	Robbins, IL
Jackson Park Supportive Living	Chicago, IL
Grand Regency of Peoria	Peoria, IL

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
Grand Lifestyles	Skokie, IL	Management Co.
Coles IL SLF Realty	Chicago, IL	Building Co.
Grand at Twin Lakes	Palatine, IL	Ind. Living

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? \$

(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	N/A			\$	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

Facility Name: Coles Supportive Living

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VIII. OWNERSHIP COSTSA. 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	\$ 231,563	35	\$ 70,250	\$ (161,313)	\$ 512,563	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Total From Supplemental Page 5's				233,266		20	11,663	11,663	29,675	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)				\$ 2,692,013	\$ 231,563		\$ 81,913	\$ (149,650)	\$ 542,238	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	\$ 1,014,116	\$	\$ 101,411	101,411		\$ 483,077	18
19	Vehicles	9,522		1,904	1,904		5,712	19
20	TOTAL (lines 18 and 19)	\$ 1,023,638	\$	\$ 103,315	103,315		\$ 488,789	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

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	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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.

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
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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.

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	2	3	4	5	6		8. Is movable equipment rental included in building rental?
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*		☐ YES ☐ NO
3	Original Building			/ /	\$			3	9. Rental amount for movable equipment \$ 5,676
4	Additions			/ /				4	
5				/ /				5	
6	Allocated from Grand Lifestyle			/ /	9,821			6	
7	TOTAL				\$ 9,821			7	

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

9. Rental amount for movable equipment \$ 5,676

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

X. INTEREST EXPENSE

	1	2		3	4	6		7	8	9	
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1	MB Financial		X	Mortgage	/ /	\$	6,853,623	/ /		\$ 271,246	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	6,853,623			\$ 271,246	7
	B. Non-Facility Related										
8	Interest Income		X		/ /			/ /		-7,883	8
9	Interest Income - Bldg Co				/ /			/ /		-293	9
10	TOTALS (lines 7, 8 and 9)					\$	6,853,623			\$ 263,070	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.

STATE OF ILLINOIS

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Facility Name: Coles Supportive Living

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,286,205	\$ 1,390,171	1
2	Cash-Patient Deposits	5,562	5,562	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	699,001	698,995	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	118,023	132,901	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		1,061,275	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,108,791	\$ 3,288,904	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		305,000	13
14	Buildings, at Historical Cost		2,824,346	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	299,995	1,196,248	16
17	Accumulated Depreciation (book methods)	(299,995)	(1,432,339)	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):	196,824	2,768,711	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 196,824	\$ 5,661,966	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,305,615	\$ 8,950,870	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 98,273	\$ 101,625	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		107,299	29
30	Accrued Salaries Payable	89,844	89,844	30
31	Accrued Taxes Payable	139,793	321,813	31
32	Accrued Interest Payable		22,473	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36		93,730	184,013	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 421,640	\$ 827,067	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		6,746,324	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43		820,171	869,008	43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 820,171	\$ 7,615,332	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,241,811	\$ 8,442,399	45
46	TOTAL EQUITY	\$ 1,063,804	\$ 508,471	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,305,615	\$ 8,950,870	47

*(See instructions.)

Facility Name: Coles Supportive Living

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

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	\$ 5,039,320	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 5,039,320	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	7,883	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 7,883	14
	D. Other Revenue (specify):		
15		329,425	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 329,425	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 5,376,628	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	967,527	19
20	Health Care/ Personal Care	508,674	20
21	General Administration	882,688	21
	B. Capital Expense		
22	Ownership	780,308	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 3,139,197	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 2,237,431	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 2,237,431	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 3,809,567	32
33	Private Pay - Net Inpatient Revenue	1,229,753	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 5,039,320	37