

		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.

I. Facility ID Number: 1000053

Facility Name: HICKORY ESTATES OF PANA

Address: 101 NORTH HICKORY PANA 62557
 Number City Zip Code

County: CHRISTIAN

Telephone Number: (217) 562-2022 **Fax #** 217 562-2027

Federal Employer ID Number: _____

Date Current Owners were Certified: 12--12-05

Type of Ownership:

☐ 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 _____	

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

Name: JEFFREY W COPLEY **Telephone Number:** (217) 562-3121
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 01-01-16 to 12-31-16
 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) JEFFREY W COPLEY

(Title) SECRETARY/ TREASURER

**Paid
Preparer**

(Signed) _____ (Date) _____

(Print Name Jaon Race
 and Title) Financial Manager

(Firm Name Regional Housing Development
 & Address) 101 West Sheridan Ave,

(Telephone) 217 632-7723 **Fax #** ()

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

Facility Name HICKORY ESTATES OF PANAReport Period Beginning: 01-01-16 Ending: 12-31-16

III. STATISTICAL DATA

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

Date of change in certified units 12-12-05

	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	39	Single Unit Apartment	39	14,235	1
2	7	Double Unit Apartment	7	2,555	2
3		Other			3
4	46	TOTALS	46	16,790	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	3,415	9,209		12,624	5
6	Double Unit		2,288		2,288	6
7	Other					7
8	TOTALS	3,415	11,497		14,912	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.81%

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

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

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐I. Is your fiscal year identical to your tax year? ☒ YES ☐ NOTax Year: 2016 Fiscal Year: 2016

* 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 therequired 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 therequired 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 facilitymake all of the required payments of interest and principle?
If no, explain.

Facility Name: HICKORY ESTATES OF PANA

Report Period Beginning:

01-01-16

Ending:

12-31-16

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	137,242	132,682	2,430	272,355		272,355	1
2	Housekeeping, Laundry and Maintenance	15,819		24,527	40,346		40,346	2
3	Heat and Other Utilities			72,039	72,039		72,039	3
4	Other (specify):			8,357	8,357		8,357	4
5	TOTAL General Services	153,061	132,682	107,353	393,096		393,096	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	147,374	26,072		173,447		173,447	6
7	Activities and Social Services	19,013	7,257		26,270		26,270	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	166,387	33,330		199,717		199,717	9
	C. General Administration							
10	Administrative and Clerical	39,146	3,723	52,728	95,597		95,597	10
11	Marketing Materials, Promotions and Advertising			12,625	12,625		12,625	11
12	Employee Benefits and Payroll Taxes	57,513			57,513		57,513	12
13	Insurance-Property, Liability and Malpractice			16,765	16,765		16,765	13
14	Other (specify):			10,573	10,573		10,573	14
15	TOTAL General Administration	96,659	3,723	92,691	193,073		193,073	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	416,108	169,735	200,043	785,886		785,886	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			5,987	5,987		5,987	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			228,000	228,000		228,000	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			233,987	233,987		233,987	23
24	GRAND TOTAL (Sum of lines 16 and 23)	416,108	169,735	434,030	1,019,873		1,019,873	24

Other Explained: IV. COST CENTER EXPENSES
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Line A.4.3	6033 Auto/ Gas Expense	\$	321.40
	6034 Auto Repair/ Maint	\$	202.97
	6140 Fire Alarm Serices	\$	1,977.74
	6270 Pest Control	\$	1,599.51
	6225 Lawn Mowing	\$	4,255.00
Total		\$	8,356.62

Line C.14.3	6125 Employee Recognition	\$	2,131.35
	6200 Legal/ Professional	\$	500.00
	6201 Auditor/ Fee Accountant	\$	4,982.68
	6210 Licensing Fees	\$	1,003.98
	6330 Training/ Conferences/ Education	\$	1,955.00
Total		\$	10,573.01

Facility Name: HICKORY ESTATES OF PANA

Report Period Beginning 01-01-16

Ending:

12-31-16

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	1	21.00	2
3	Certified Nurse Assistants	9	9.92	3
4	Activity Director & Assistants	1	10.25	4
5	Social Service Workers			5
6	Head Cook	1	16.83	6
7	Cook Helpers/Assistants	12	8.67	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	9.75	10
11	Laundry			11
12	Managers	1	19.83	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	26	\$ 96.25	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				\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1	C.C.I.C.S.	\$ 23,069	1
2			2
Total		\$ 23,069	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

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
C.C.I.C.S.		PANA		501C3	

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).

Facility Name: HICKORY ESTATES OF PANA

Report Period Beginning:

01-01-16

Ending:

12-31-16

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

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	46		2005	2004	\$ 3,345,189	\$ 121,611	28	\$ 121,611		\$ 1,397,907	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	BUILDING AND SITE IMPROVEMENT			2005	37,391	2,492	16	2,492		28,665	6
7				2006	5,891	392	16	392		4,117	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)				\$ 3,388,471	\$ 124,495		\$ 124,495		\$ 1,430,689	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	\$	\$	\$	\$		\$	18
19	Vehicles	5,987				5	5,987	19
20	TOTAL (lines 18 and 19)	\$ 5,987	\$	\$	\$		\$ 5,987	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

Ending: 12-31-16

Facility Name: HICKORY ESTATES OF PANA

Report Period Beginning: 01-01-16

Ending:

12-31-16

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-16

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 223,731	\$ 446,794	1
2	Cash-Patient Deposits	39,831	39,831	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	100,208	100,208	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 363,770	\$ 586,833	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,076,530	13
14	Buildings, at Historical Cost		11,381,301	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	13,487	124,359	16
17	Accumulated Depreciation (book methods)	(11,222)	(5,212,825)	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): BUILDING IMPROVEMENTS	17,284	449,404	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 19,548	\$ 7,818,769	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 383,318	\$ 8,405,602	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 11,300	\$ 37,317	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,800	39,800	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	5,654	190,262	30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35			100,132	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 56,753	\$ 367,510	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable		5,950,084	38
39	Mortgage Payable			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)	\$	\$ 5,950,084	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 56,753	\$ 6,317,595	45
46	TOTAL EQUITY	\$ 326,565	\$ 2,088,007	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 383,318	\$ 8,405,602	47

*(See instructions.)

Facility Name: CCICS

Report Period Beginning: 01-01-16

Ending:

12-31-16

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-16

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 223,063	\$	1
2	Cash-Patient Deposits			2
	Accounts & Short-Term Notes Receivable-			
3	Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
	TOTAL Current Assets			
10	(sum of lines 1 thru 9)	\$ 223,063	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,076,530		13
14	Buildings, at Historical Cost	11,381,301		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	110,871		16
17	Accumulated Depreciation (book methods)	(5,201,602)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): BUILDING IMPROVEMENTS	432,120		23
	TOTAL Long-Term Assets			
24	(sum of lines 11 thru 23)	\$ 7,799,220	\$ 0	24
	TOTAL ASSETS			
25	(sum of lines 10 and 24)	\$ 8,022,283	\$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 26,017	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	184,608		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	see attached	100,132		35
36				36
	TOTAL Current Liabilities			
37	(sum of lines 26 thru 36)	\$ 310,757	\$ 0	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	5,950,084		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
	TOTAL Long-Term Liabilities			
44	(sum of lines 38 thru 43)	\$ 5,950,084	\$ 0	44
	TOTAL LIABILITIES			
45	(sum of lines 37 and 44)	\$ 6,260,841	\$ 0	45
46	TOTAL EQUITY	\$ 1,761,442	\$	46
47	TOTAL LIABILITIES AND EQUITY			
	(sum of lines 45 and 46)	\$ 8,022,283	\$ 0	47

*(See instructions.)

Other Current Liabilities

Line 35	213700 Pilot	85157.6
	24000 Payroll Liabilities	14974.5
	Total	100132

Facility Name: HICKORY ESTATES OF PANA

Report Period Beginning: 01-01-16

Ending:

12-31-16

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	\$ 1,191,268	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,191,268	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	3,505	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 3,505	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
	D. Other Revenue (specify):		
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,194,773	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	393,096	19
20	Health Care/ Personal Care	173,447	20
21	General Administration	193,073	21
	B. Capital Expense		
22	Ownership	233,987	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)	\$ 993,603	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 201,170	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 201,170	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,167,119	32
33	Private Pay - Net Inpatient Revenue	24,149	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,191,268	37