

		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: 1000119

Facility Name: Hickory Grove Apartments SLF

Address: 400 South Adams

Carthage

62321

County: Hancock

Telephone Number: (217) 357-8800 Fax # (217) 357-8890

Federal Employer ID Number:

Date Current Owners were Certified: 10/30/2009 Interim Certification

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: Teresa Smith

Telephone Number: (217) 357-8573

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 07/01/2015 to 06/30/2016 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)

10/30/2015

(Type or Print Name) Teresa Smith

(Title) Chief Financial Officer

Paid Preparer

(Signed)

(Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () 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

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	17	Single Unit Apartment	17	6,222	1
2	5	Double Unit Apartment	5	1,830	2
3		Other		1,243	3
4	22	TOTALS	22	9,295	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	2,915	3,957		6,872	5
6	Double Unit	366	678		1,044	6
7	Other	366	877		1,243	7
8	TOTALS	3,647	5,512		9,159	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.54%

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

166 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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30 Fiscal Year: 6/30

* 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? Yes If yes, did the facility make all of the required payments of interest and principle? Yes
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: Hickory Grove Apartments SLF

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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			
	A. General Services							
1	Dietary and Food Purchase	45,347	70,334	(835)	114,846		114,846	1
2	Housekeeping, Laundry and Maintenance		9,031	20,644	29,675		29,675	2
3	Heat and Other Utilities			30,268	30,268		30,268	3
4	Other (specify):							4
5	TOTAL General Services	45,347	79,365	50,077	174,789		174,789	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	197,120	4,212		201,332		201,332	6
7	Activities and Social Services		4,030	3,520	7,550		7,550	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	197,120	8,242	3,520	208,882		208,882	9
	C. General Administration							
10	Administrative and Clerical	39,571	11,137	28,873	79,581		79,581	10
11	Marketing Materials, Promotions and Advertising			1,639	1,639		1,639	11
12	Employee Benefits and Payroll Taxes			55,572	55,572		55,572	12
13	Insurance-Property, Liability and Malpractice			20,499	20,499		20,499	13
14	Other (specify):			6,000	6,000		6,000	14
15	TOTAL General Administration	39,571	11,137	112,583	163,291		163,291	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	282,038	98,743	166,180	546,962		546,962	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			98,565	98,565		98,565	17
18	Interest			154,287	154,287		154,287	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			252,853	252,853		252,853	23
24	GRAND TOTAL (Sum of lines 16 and 23)	282,038	98,743	419,033	799,815		799,815	24

Facility Name: Hickory Grove Apartments SLF

Report Period Beginning 07/01/2015 Ending: 06/30/2016

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 20.50	1
2	Licensed Practical Nurses	1	16.91	2
3	Certified Nurse Assistants	6	11.84	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	2	9.79	6
7	Cook Helpers/Assistants	0	14.26	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	36.28	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 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

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	\$	1
2		2
Total		\$ 3

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? \$

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 Grove Apartments SLF

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	22		2009		\$ 3,063,804	\$ 76,595	40	\$ 76,595	\$	510,193	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Land		2009		35,260	2,687	15	2,351	(336)	15,510	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)				\$ 3,099,064	\$ 79,282		\$ 78,946	\$ (336)	\$ 525,703	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	\$ 179,794	\$ 19,283	\$ 19,977	694	9	\$ 114,502	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)		\$ 179,794	\$ 19,283	\$ 19,977	694	\$ 114,502	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

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		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 \$ _____ 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.
4	Additions			/ /				4	
5				/ /				5	
6				/ /				6	
7	TOTAL				\$			7	

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	PR Mortgage		X	Permanent Mortgage	7/6/10	\$ 2,700,000	\$ 2,598,241	7/1/35	6.5800	\$ 144,286	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 2,700,000	\$ 2,598,241			\$ 144,286	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 2,700,000	\$ 2,598,241			\$ 144,286	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: Hickory Grove Apartments SLF

Report Period Beginning: 07/01/2015

Ending:

06/30/2016

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2016

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 172,323	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 7,000)	49,642		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,294		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	100		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 233,359	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	64,514		13
14	Buildings, at Historical Cost	3,063,804		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	179,794		16
17	Accumulated Depreciation (book methods)	(640,205)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	185,566		20
21	Restricted Funds	215,572		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,069,045	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,302,404	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 792	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	30,209		29
30	Accrued Salaries Payable	12,992		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				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 43,993	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	280,713		38
39	Mortgage Payable	2,598,241		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)	\$ 2,878,954	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,922,947	\$	45
46	TOTAL EQUITY	\$ 379,457	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 3,302,404	\$	47

*(See instructions.)

Facility Name: Hickory Grove Apartments SLF

Report Period Beginning: 07/01/2015

Ending:

06/30/2016

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	\$ 917,699	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 917,699	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	4,059	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 4,059	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)	\$ 921,758	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	174,789	19
20	Health Care/ Personal Care	208,882	20
21	General Administration	163,291	21
	B. Capital Expense		
22	Ownership	252,853	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)	\$ 799,815	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 121,943	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 121,943	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$	32
33	Private Pay - Net Inpatient Revenue		33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$	37

Nature of Purchase Facility	Book Value	Actual Cost
Meals	0.00	0.00
Fiscal Services	12,950.70	12,950.70
Maintenance	4,944.00	4,944.00

		Costs Per General Ledger				Reclassification	Adjusted	
Operating Expenses		Salary/Wage	Supplies	Other	Total	d Adjustme	Total	
		1	2	3	4	5	6	
2	Housekeeping, Laundry and Maintenance		9,031	20,644	29,675	(3,650)	26,025	2

Adjustment for nonallowable expenses (Resident Cable)

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