

		FOR BHF USE			

LL2

Supportive Living Facility

**2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2014)**

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>1000119</u></p> <p>Facility Name: <u>Hickory Grove Apartments SLF</u></p> <p>Address: <u>400 South Adams</u> <u>Carthage</u> <u>62321</u> <small>Number City Zip Code</small></p> <p>County: <u>Hancock</u></p> <p>Telephone Number: (<u>217</u>) <u>357-6550</u> Fax # (<u>217</u>) <u>357-6549</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10/30/2009 Interim Certification</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input checked="" type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Teresa Smith</u> Telephone Number: (<u>217</u>) <u>357-8573</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<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>07/01/2013</u> to <u>06/30/2014</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%; border: none;"> <tr> <td style="width:30%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">10/31/2014</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Teresa Smith</u></td> <td style="border: none;">(Date)</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date)</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">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>	Officer or Administrator of Provider	(Signed) _____	10/31/2014		(Type or Print Name) <u>Teresa Smith</u>	(Date)		(Title) <u>Chief Financial Officer</u>		Paid Preparer	(Signed) _____	(Date)		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) () _____ Fax # () _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County																																												
IRS Exemption Code _____	<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 _____																																													
Officer or Administrator of Provider	(Signed) _____	10/31/2014																																												
	(Type or Print Name) <u>Teresa Smith</u>	(Date)																																												
	(Title) <u>Chief Financial Officer</u>																																													
Paid Preparer	(Signed) _____	(Date)																																												
	(Print Name and Title) _____																																													
	(Firm Name & Address) _____																																													
	(Telephone) () _____ Fax # () _____																																													

Facility Name: Hickory Grove Apartments SLF

Report Period Beginning:

07/01/2013

Ending: 06/30/2014

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	48,584	60,953	4,299	113,836		113,836	1
2	Housekeeping, Laundry and Maintenance		10,752	13,511	24,263	(4,617)	19,645	2
3	Heat and Other Utilities			25,795	25,795		25,795	3
4	Other (specify):							4
5	TOTAL General Services	48,584	71,705	43,605	163,894	(4,617)	159,277	5
B. Health Care and Programs								
6	Health Care/ Personal Care	174,932	4,112		179,045		179,045	6
7	Activities and Social Services		6,643	5,114	11,757	(93)	11,664	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	174,932	10,755	5,114	190,801	(93)	190,709	9
C. General Administration								
10	Administrative and Clerical	57,708	19,523	25,846	103,076		103,076	10
11	Marketing Materials, Promotions and Advertising			2,039	2,039		2,039	11
12	Employee Benefits and Payroll Taxes			36,091	36,091		36,091	12
13	Insurance-Property, Liability and Malpractice			15,214	15,214		15,214	13
14	Other (specify):			5,838	5,838		5,838	14
15	TOTAL General Administration	57,708	19,523	85,028	162,259		162,259	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	281,224	101,983	133,747	516,954	(4,710)	512,244	16
Capital Expenses								
D. Ownership								
17	Depreciation			99,789	99,789		99,789	17
18	Interest			200,636	200,636		200,636	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			300,426	300,426		300,426	23
24	GRAND TOTAL (Sum of lines 16 and 23)	281,224	101,983	434,173	817,379	(4,710)	812,669	24

Facility Name: Hickory Grove Apartments SLF

Report Period Beginning 07/01/2013

Ending:

06/30/2014

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0	\$ 21.63	1
2	Licensed Practical Nurses	1	16.57	2
3	Certified Nurse Assistants	6	10.92	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	2	9.87	6
7	Cook Helpers/Assistants	1	9.16	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	23.94	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	10	\$	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	\$	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

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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 Grove Apartments SLF

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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	\$ 76,586	40	\$ 76,595	\$ 9	\$ 357,002	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Land		2009		35,260	2,634	15	2,351	(283)	10,136	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	\$ 79,220		\$ 78,946	\$ (274)	\$ 367,138	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	\$ 152,334	\$ 20,569	\$ 19,042	(1,527)	8	\$ 76,830	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 152,334	\$ 20,569	\$ 19,042	(1,527)		\$ 76,830	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: Hickory Grove Apartments SLF

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		PR Mortgage		X	Permanent Mortgage	7/6/10	\$ 2,700,000	\$ 2,636,697	7/1/35	6.5800	\$ 192,096	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 2,700,000	\$ 2,636,697			\$ 192,096	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 2,700,000	\$ 2,636,697			\$ 192,096	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: 07/01/2013

Ending:

06/30/2014

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 214,735	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	75,892		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,308		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)	\$ 298,035	\$	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	152,334		16
17	Accumulated Depreciation (book methods)	(443,969)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	205,568		20
21	Restricted Funds	93,298		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,135,550	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,433,585	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 13,479	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	450		29
30	Accrued Salaries Payable	19,245		30
31	Accrued Taxes Payable	10,052		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)	\$ 43,226	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	549,553		38
39	Mortgage Payable	2,636,697		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)	\$ 3,186,250	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,229,476	\$	45
46	TOTAL EQUITY	\$ 204,110	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 3,433,585	\$	47

*(See instructions.)

Facility Name: Hickory Grove Apartments SLF

Report Period Beginning: 07/01/2013

Ending:

06/30/2014

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

	1	Amount	
	Revenue		
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 847,606	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 847,606	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	215	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 215	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	16,882	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 16,882	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)	\$ 864,703	18

	2	Amount	
	Expenses		
	A. Operating Expenses		
19	General Services	159,277	19
20	Health Care/ Personal Care	190,709	20
21	General Administration	162,259	21
	B. Capital Expense		
22	Ownership	300,426	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)	\$ 812,671	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 52,032	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 52,032	31

Nature of Purchase Facility	Book Value	Actual Cost
Meals	0.00	0.00
Fiscal Services	12,573.22	12,573.22
Maintenance	5,434.00	5,434.00

Operating Expenses		Salary/Wage	Supplies	Other	Total	Adjustment	Total		
7		1	2	3	4	5	6		
7	Activities and Social Services		6,643	5,114	11,757	(93)	11,664	7	Adjustment for nonallowable expenses (alcohol)
2	Housekeeping, Laundry and Maintenance		10,752	13,511	24,263	(4,617)	19,645	2	Adjustment for nonallowable expenses (Resident Cable)

