

		FOR BHF USE			

LL2

Supportive Living Facility

**2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)**

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
Number City Zip Code

County: Hancock

Telephone Number: (217) 357-6550 Fax # (217) 357-6549

Federal Employer ID Number: _____

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

Type of Ownership:

<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 _____	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/09 to 06/30/2010 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) _____	11/1/2010
	(Type or Print Name) <u>Teresa Smith</u>	(Date)
Paid Preparer	(Title) <u>Chief Financial Officer</u>	
	(Signed) _____	(Date)
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (_____)	Fax # (_____)

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

Name: Teresa Smith **Telephone Number:** (217)357-8573
Email Address: _____

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 Grove Apartments SLF

Report Period Beginning: 07/01/09 Ending: 06/30/2010

III. STATISTICAL DATA

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

Date of change in certified units 04/01/2010

	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	4,114	1
2	5	Double Unit Apartment	5	1,210	2
3		Other		568	3
4	22	TOTALS	22	5,892	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	1,476	770		2,246	5
6	Double Unit		758		758	6
7	Other		568		568	7
8	TOTALS	1,476	2,096		3,572	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 60.62%

D. Indicate the number of paid bed-hold days the SLF had during this year
15 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 4 (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: 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:

07/01/09

Ending: 06/30/2010

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	50,054	50,191		50,191	1
2	Housekeeping, Laundry and Maintenance		4,938	6,869	11,807		11,807	2
3	Heat and Other Utilities			22,739	22,738		22,738	3
4	Other (specify):							4
5	TOTAL General Services		5,075	79,662	84,736		84,736	5
B. Health Care and Programs								
6	Health Care/ Personal Care	77,104	62		77,166		77,166	6
7	Activities and Social Services		624		624		624	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	77,104	686		77,790		77,790	9
C. General Administration								
10	Administrative and Clerical	22,637	1,545	7,783	31,965		31,965	10
11	Marketing Materials, Promotions and Advertising		935	5,315	6,250		6,250	11
12	Employee Benefits and Payroll Taxes			23,582	23,582		23,582	12
13	Insurance-Property, Liability and Malpractice			6,623	6,623		6,623	13
14	Other (specify): legal fees, freight & sales tax			1,017	1,017		1,017	14
15	TOTAL General Administration	22,637	2,480	44,320	69,437		69,437	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	99,741	8,241	123,982	231,963		231,963	16
Capital Expenses								
D. Ownership								
17	Depreciation			66,056	66,056		66,056	17
18	Interest			71,797	71,797		71,797	18
19	Real Estate Taxes			8,400	8,400		8,400	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			146,253	146,253		146,253	23
24	GRAND TOTAL (Sum of lines 16 and 23)	99,741	8,241	270,235	378,216		378,216	24

Facility Name: Hickory Grove Apartments SLF

Report Period Beginning: 07/01/09 Ending: 06/30/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.3	\$ 17.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	4.5	10.43	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers (Manager is LPN)	1.0	16.00	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	5.8	\$ 11.74	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
Hancock County Nursing Home		Carthage		Healthcare	
_____		_____		_____	
_____		_____		_____	

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:

07/01/09

Ending:

06/30/2010

VIII. OWNERSHIP COSTS

A. Purchase price of land 29,254 Year land was acquired 2009

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	\$ 3,037,857	\$ 50,631	40	\$ 50,631	\$ (0)	\$ 50,631	1
2											2
3											3
4											4
5											5
Improvement Type											
6	LAND		2009		32,696	1,364	15	1,453	89	1,364	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)				\$ 3,070,553	\$ 51,995		\$ 52,084	\$ 89	\$ 51,995	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	\$ 128,859	\$ 9,604	\$ 9,545	(59)	9	\$ 9,604	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 128,859	\$ 9,604	\$ 9,545	(59)		\$ 9,604	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: 07/01/09

Ending: 6/30/2010

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**	NO			Amount of Note	Balance			Interest Rate (4 Digits)	Reporting Period Int. Expense
			YES	NO		Date of Note	Original		Maturity Date			
		A. Directly Facility Related										
		Long-Term										
1		PR Mortgage		X	Construction Loan	7/1/09	\$ 2,076,767	\$ 2,076,767	7/6/10	0.0400	\$ 71,797	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 2,076,767	\$ 2,076,767			\$ 71,797	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 2,076,767	\$ 2,076,767			\$ 71,797	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: 07/01/09

Ending:

06/30/2010

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2010

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 93,956	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	25,475		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	376		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(47,441)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 72,366	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	61,950		13
14	Buildings, at Historical Cost	3,209,474		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	128,859		16
17	Accumulated Depreciation (book methods)	(61,599)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(4,457)		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)	\$ 3,334,227	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,406,593	\$	25

*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 16,267	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,231		30
31	Accrued Taxes Payable	8,400		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)	\$ 37,898	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,320,900		38
39	Mortgage Payable	2,076,767		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)	\$ 3,397,667	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,435,564	\$	45
46	TOTAL EQUITY	\$ (28,971)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 3,406,593	\$	47

Facility Name: Hickory Grove Apartments SLF

Report Period Beginning: 07/01/09

Ending:

06/30/2010

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 326,691	1
2	Discounts and Allowances	(7,642)	2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 319,049	3
B. Other Operating Revenue			
4	Special Services(Link Card Meal Revenue)		4
5	Other Health Care Services	320	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	422	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 742	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			15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 319,791	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	84,736	19
20	Health Care/ Personal Care	77,790	20
21	General Administration	69,437	21
B. Capital Expense			
22	Ownership	146,253	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)	\$ 378,216	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (58,425)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (58,425)	31

Nature of Purchase	Facility Book Value	Actual Cost
Meals	\$49,604.25	\$49,604.25
Fiscal Services	\$4,440.00	\$4,440.00
Maintenance	\$5,366.00	\$5,366.00