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 (Number) PANA (City) 62557 (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.		
		X	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 and Title) Jaon Race, Financial Manager
(Firm Name & Address) Regional Housing Development, 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 PANA Report 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 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 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 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [X] 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*
[X]	[ ]	[ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax 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 the required 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 the required 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 facility make 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 Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclassifications and Adjustments 5	Adjusted Total 6	
	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

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
	6201Auditor/ 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		OTHER RELATED BUSINESS ENTITIES		
Name 1	City 2	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 [X]

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 [X]

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

Facility Name: HICKORY ESTATES OF PANA **Report Period Beginning:** 01-01-16 **Ending:** 12-31-16

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 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 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 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related Long-Term										
1					/ /	$	$	/ /		$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$	$			$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$	$			$	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 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
3	Accounts & Short-Term Notes Receivable-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
10	**TOTAL Current Assets (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
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): BUILDING IMPROVEMENTS	432,120		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,799,220	$ 0	24
25	**TOTAL ASSETS (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
37	**TOTAL Current Liabilities (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
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 5,950,084	$ 0	44
45	**TOTAL LIABILITIES (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.)

	I. Revenue	1 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

	II. Expenses	2 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