

		FOR BHF USE			

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Supportive Living Facility

**2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2007)**

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.</p> <p>Facility Name: <u>The Village at Morse Farm</u></p> <p>Address: <u>1050 W Main</u> <u>Carlinville</u> <u>62626</u> <small>Number City Zip Code</small></p> <p>County: <u>Macoupin</u></p> <p>Telephone Number: (<u>217</u>) <u>854-8606</u> Fax # (<u>217</u>) <u>854-8749</u></p> <p>Federal Employer ID Number: <u>37-6006948</u></p> <p>Date Current Owners were Certified: <u>6/26/2006</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input checked="" type="checkbox"/> Other <u>Local</u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td><input type="checkbox"/> Limited Liability Co.</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Other _____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Lori Beeler</u> Telephone Number: (<u>217</u>) <u>854-8606</u></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 type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input checked="" type="checkbox"/> Other <u>Local</u>		<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>10/01/06</u> to <u>09/30/07</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 border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Margaret (Peg) Barkley</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____</td> <td></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) _____	(Date) _____	(Type or Print Name) <u>Margaret (Peg) Barkley</u>			(Title) <u>Chief Executive Officer</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____	
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Facility Name: The Village at Morse Farm

Report Period Beginning:

10/01/06

Ending:

09/30/07

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	54,552	63,638		118,190		118,190	1
2	Housekeeping, Laundry and Maintenance	16,059	8,779	10,854	35,692		35,692	2
3	Heat and Other Utilities			58,601	58,601		58,601	3
4	Other (specify): Garbage Removal			1,196	1,196		1,196	4
5	TOTAL General Services	70,610	72,418	70,650	213,678		213,678	5
B. Health Care and Programs								
6	Health Care/ Personal Care	79,981	391	8,608	88,980		88,980	6
7	Activities and Social Services		598		598		598	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	79,981	989	8,608	89,578		89,578	9
C. General Administration								
10	Administrative and Clerical	54,594	13,506		68,099		68,099	10
11	Marketing Materials, Promotions and Advertising		10,692		10,692		10,692	11
12	Employee Benefits and Payroll Taxes	39,640			39,640		39,640	12
13	Insurance-Property, Liability and Malpractice		20,910		20,910		20,910	13
14	Other (specify): Management Fee			35,834	35,834		35,834	14
15	TOTAL General Administration	94,233	45,108	35,834	175,175		175,175	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	244,825	118,515	115,092	478,432		478,432	16
Capital Expenses								
D. Ownership								
17	Depreciation			98,289	98,289		98,289	17
18	Interest			312,379	312,379		312,379	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			410,667	410,667		410,667	23
24	GRAND TOTAL (Sum of lines 16 and 23)	244,825	118,515	525,759	889,099		889,099	24

Facility Name: The Village at Morse Farm

Report Period Beginning 10/01/06 Ending: 09/30/07

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	15.00	2
3	Certified Nurse Assistants	5	8.50	3
4	Activity Director & Assistants	1	10.50	4
5	Social Service Workers			5
6	Head Cook	1	10.00	6
7	Cook Helpers/Assistants	11	7.50	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	7.75	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	20	\$	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	N/A			\$	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		\$

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 <u>1</u>	City <u>2</u>

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
Macoupin County Housing	Carlinville	Housing Authority

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: Macoupin County Housing Authority 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: The Village at Morse Farm

Report Period Beginning: 10/01/06

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VIII. OWNERSHIP COSTS

A. Purchase price of land 78,555 Year land was acquired 2007

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		2006	2006	\$ 5,469,822	\$ 98,019	40	\$ 98,019	\$	\$ 98,019	1
2											2
3											3
4											4
5											5
Improvement Type											
6											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)				\$ 5,469,822	\$ 98,019		\$ 98,019	\$	\$ 98,019	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							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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	Office Equipment	\$ 2,694	\$ \$ 454	\$ \$ 454	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 2,694	\$ 454	\$ 454	24

Facility Name: The Village at Morse Farm

Report Period Beginning: 10/01/06

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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	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	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	Midland Sates Bank		X	Mortgage	6/8/07	\$ 3,992,553	\$ 3,974,550	6/8/12	6.0000	\$ 301,059
2	Dietzen Development		X	Mortgage	7/9/07	1,134,132	1,115,452	7/9/08	6.0000	11,320
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 5,126,685	\$ 5,090,002			\$ 312,379
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 5,126,685	\$ 5,090,002			\$ 312,379

* 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.

STATE OF ILLINOIS

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Facility Name: The Village at Morse Farm

Report Period Beginning: 10/01/06

Ending:

09/30/07

09/30/07

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/07

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,385	\$	1
2	Cash-Patient Deposits	42,470		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	30,181		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,444		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 80,480	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	78,555		13
14	Buildings, at Historical Cost	5,469,822		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,694		16
17	Accumulated Depreciation (book methods)	(98,473)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,452,598	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,533,078	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 22,472	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,600		28
29	Short-Term Notes Payable	125,563		29
30	Accrued Salaries Payable	3,065		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	20,273		32
33	Deferred Compensation	11,972		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Mgmt/Mnt Fee Payable	44,485		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 270,430	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	4,974,418		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)	\$ 4,974,418	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,244,848	\$	45
46	TOTAL EQUITY	\$ 288,230	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,533,078	\$	47

*(See instructions.)

Facility Name: The Village at Morse Farm

Report Period Beginning: 10/01/06

Ending:

09/30/07

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	\$ 720,556	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 720,556	3
B. Other Operating Revenue			
4	Special Services	1,254	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	5,228	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 6,482	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	824	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 824	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)	\$ 727,862	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	213,678	19
20	Health Care/ Personal Care	89,578	20
21	General Administration	175,175	21
B. Capital Expense			
22	Ownership		22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses	410,667	24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 889,098	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (161,236)	29
30	Income Taxes		30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (161,236)	31