

		FOR BHF USE			

LL2

Supportive Living Facility

**2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2008)**

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>854-8142</u> Fax # <u>217</u> <u>854-9600</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 style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" 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>Municipal</u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</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> Email Address: <u>lori@teamhousingcenter.com</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" 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>Municipal</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>10/1/2007</u> to <u>9/30/2008</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%"> <tr> <td style="width:20%">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Margaret Barkley</u> (Title) <u>CEO</u> `11</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (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) _____ (Type or Print Name) <u>Margaret Barkley</u> (Title) <u>CEO</u> `11	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) Fax # (_____)
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" 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>Municipal</u>																											
	<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) _____ (Type or Print Name) <u>Margaret Barkley</u> (Title) <u>CEO</u> `11																												
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) Fax # (_____)																												

Facility Name The Village At Morse Farm

Report Period Beginning: 10/1/2007 Ending: 9/30/2008

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	39	Single Unit Apartment	39	14,274	1
2	7	Double Unit Apartment	7	2,562	2
3		Other			3
4	46	TOTALS	46	16,836	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	2,939	10,565		13,504	5
6	Double Unit	366	2,134		2,500	6
7	Other					7
8	TOTALS	3,305	12,699		16,004	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 95.06%

D. Indicate the number of paid bed-hold days the SLF had during this year
65 Also, indicate the number of unpaid bed-hold days the SLF had during this year. Zero (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: 9/30 Fiscal Year: 9/30

* 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? 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: The Village At Morse Farm

Report Period Beginning:

10/1/2007

Ending:

9/30/2008

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	56,446	98,718	1,533	156,697		156,697	1
2	Housekeeping, Laundry and Maintenance	14,846	28,341		43,187		43,187	2
3	Heat and Other Utilities			67,636	67,636		67,636	3
4	Other (specify):							4
5	TOTAL General Services	71,293	127,059	69,169	267,520		267,520	5
B. Health Care and Programs								
6	Health Care/ Personal Care	109,344		4,545	113,889		113,889	6
7	Activities and Social Services		5,516		5,516		5,516	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	109,344	5,516	4,545	119,405		119,405	9
C. General Administration								
10	Administrative and Clerical	49,909	16,095	60,044	126,049		126,049	10
11	Marketing Materials, Promotions and Advertising		7,081		7,081		7,081	11
12	Employee Benefits and Payroll Taxes			52,401	52,401		52,401	12
13	Insurance-Property, Liability and Malpractice			12,296	12,296		12,296	13
14	Other (specify): Remove House & reimbursed insurance expenses				57,597		57,597	14
15	TOTAL General Administration	49,909	23,177	124,741	255,424		255,424	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	230,545	155,752	198,455	642,349		642,349	16
Capital Expenses								
D. Ownership								
17	Depreciation			124,889	124,889		124,889	17
18	Interest			324,271	324,271		324,271	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			449,161	449,161		449,161	23
24	GRAND TOTAL (Sum of lines 16 and 23)	230,545	155,752	647,616	1,091,510		1,091,510	24

Facility Name: The Village At Morse Farm

Report Period Beginning 10/1/2007 Ending: 9/30/2008

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			2
3	Certified Nurse Assistants	5	8.75	3
4	Activity Director & Assistants	1	7.75	4
5	Social Service Workers			5
6	Head Cook	1	10.30	6
7	Cook Helpers/Assistants	2	8.00	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	8.75	10
11	Laundry			11
12	Managers	2	13.68	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	12	\$	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 <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 HA	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: _____ 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). See Attachment 1

Facility Name: The Village At Morse Farm

Report Period Beginning: 10/1/2007

Ending: 9/30/2008

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	\$ 4,970,024	\$ 124,251	40	\$ 124,251	\$	\$ 222,270	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)				\$ 4,970,024	\$ 124,251		\$ 124,251	\$	\$ 222,270	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	\$ \$ 1,092	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 2,694	\$ 454	\$ 1,092	24

Facility Name: The Village At Morse Farm

Report Period Beginning: 10/1/2007

Ending: 9/30/2008

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 States Bank		X	Mortgage	6/8/07	\$ 3,992,553	\$ 3,897,664	6/8/12	6.0000	\$ 264,395
2	Dietzen Development		X	Mortgage	7/9/07	1,134,132	1,071,511	7/9/08	6.0000	59,876
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 5,126,685	\$ 4,969,175			\$ 324,271
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 5,126,685	\$ 4,969,175			\$ 324,271

* 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: The Village At Morse Farm

Report Period Beginning: 10/1/2007

Ending:

9/30/2008

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2008

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 18,939	\$	1
2	Cash-Patient Deposits	46,119		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	59,634		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): <u>A/R Insurance Claim</u>	15,051		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 139,745	\$	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	4,970,024		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,694		16
17	Accumulated Depreciation (book methods)	(223,362)		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)	\$ 4,827,911	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,967,656	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 33,888	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,500		28
29	Short-Term Notes Payable	133,976		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	27,062		32
33	Deferred Compensation	(1,176)		33
34	Federal and State Income Taxes	939		34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 240,190	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,835,199		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)	\$ 4,835,199	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,075,388	\$	45
46	TOTAL EQUITY	\$ (107,733)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,967,656	\$	47

*(See instructions.)

Facility Name: The Village At Morse Farm

Report Period Beginning: 10/1/2007

Ending:

9/30/2008

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	\$ 1,145,228	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,145,228	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	5,312	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 5,312	11
C. Non-Operating Revenue			
12	Contributions	115	12
13	Interest and Other Investment Income	749	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 864	14
D. Other Revenue (specify):			
15	Reimbursements for Insurance Claims	24,429	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 24,429	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,175,834	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	198,860	19
20	Health Care/ Personal Care	115,421	20
21	General Administration	719,632	21
B. Capital Expense			
22	Ownership		22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses	57,597	24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 1,091,510	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 84,323	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 84,323	31

Attachment 1

Expenses paid to Macoupin County Housing Authority for Management and maintenance fees

Management Fees 57258.91

Maintenance Fees 7253.68

Cost was same to related party