

		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:** 1000022

**Facility Name:** QUINCY SENIOR AND FAMILY RESOURCE

**Address:** 639 YORK QUINCY 62301  
Number City Zip Code

**County:** ADAMS

**Telephone Number:** ( 217 ) 592-3668 Fax # (217) 592-3732

**Federal Employer ID Number:** \_\_\_\_\_

**Date Current Owners were Certified:** 04/04/2003

**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 \_\_\_\_\_ to \_\_\_\_\_ 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) <u>TODD SHACKELFORD</u>	
	(Title) <u>GENERAL AND MANAGING PARTNER</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( _____ ) _____ Fax # ( _____ ) _____	

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

**Name:** TODD SHACKELFORD **Telephone Number:** ( 217 ) 223-7904  
**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 QUINCY SENIOR AND FAMILY RESOURCE

Report Period Beginning:

Ending:

**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	51	Single Unit Apartment	51	18,615	1
2	6	Double Unit Apartment	6	2,190	2
3		Other			3
4	57	TOTALS	57	20,805	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	12,525	3,339		15,864	5
6	Double Unit	1,601	889		2,490	6
7	Other					7
8	TOTALS	14,126	4,228		18,354	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.22%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 335 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 7 **(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)

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**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

**I. Is your fiscal year identical to your tax year?**  YES  NO

Tax Year: JAN-DEC Fiscal Year: JAN-DEC

\* 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: QUINCY SENIOR AND FAMILY RESOURCE

Report Period Beginning:

Ending:

## IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
<b>A. General Services</b>								
1	Dietary and Food Purchase		209,448		209,448		209,448	1
2	Housekeeping, Laundry and Maintenance	30,902	116,587	22,200	169,689		169,689	2
3	Heat and Other Utilities			105,516	105,516	(11,643)	93,873	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	30,902	326,035	127,716	484,653	(11,643)	473,010	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	380,140	11,788	98	392,026		392,026	6
7	Activities and Social Services		13,836	26,198	40,034		40,034	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	380,140	25,624	26,296	432,060		432,060	9
<b>C. General Administration</b>								
10	Administrative and Clerical	63,665	4,957	108,086	176,708		176,708	10
11	Marketing Materials, Promotions and Advertising			9,447	9,447		9,447	11
12	Employee Benefits and Payroll Taxes	185,844			185,844		185,844	12
13	Insurance-Property, Liability and Malpractice	24,571			24,571		24,571	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	274,080	4,957	117,533	396,570		396,570	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	685,122	356,616	271,545	1,313,283	(11,643)	1,301,640	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			271,715	271,715		271,715	17
18	Interest			347,125	347,125		347,125	18
19	Real Estate Taxes			150	150		150	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): <b>MORTGAGE PREMIUM INSURANCE &amp; AMORTIZATION</b>			40,586	40,586		40,586	22
23	<b>TOTAL Ownership</b>			659,576	659,576		659,576	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	685,122	356,616	931,121	1,972,859	(11,643)	1,961,216	24

Facility Name: QUINCY SENIOR AND FAMILY RESOURCE

Report Period Beginning:

Ending:

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 22.00	1
2	Licensed Practical Nurses	2	15.00	2
3	Certified Nurse Assistants	10	9.50	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	1	8.25	10
11	Laundry	1	8.25	11
12	Managers	1	16.20	12
13	Other Administrative	1	8.25	13
14	Clerical			14
15	Marketing			15
16	Other	6	8.25	16
17	<b>Total (lines 1 thru 16)</b>	<b>23</b>	<b>\$</b>	<b>17</b>

**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
<b>Total</b>				<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

		Amount of Fee	
1	WEST CENTRAL ILLINOIS AREA AGENCY ON AGING	\$ 86,770	1
2			2
<b>Total</b>		<b>\$ 86,770</b>	<b>3</b>

**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>
NDC EQUITY FUNDS IV	NEW YORK, NY
WEST CENTRAL ILLINOIS AREA AGENCY ON AGING	QUINCY, IL

**OTHER RELATED BUSINESS ENTITIES**

Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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: QUINCY SENIOR AND FAMILY RESOURCE

Report Period Beginning:

Ending:

**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	57		2002	2002	\$ 7,006,426	\$		\$ 271,715	\$ 271,715	\$ 2,039,223	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	<b>TOTAL (lines 1 thru 16)</b>				\$ 7,006,426	\$		\$ 271,715	\$ 271,715	\$ 2,039,223	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	<b>TOTAL (lines 18 and 19)</b>	\$	\$	\$	\$		\$	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	<b>TOTALS (lines 21, 22 and 23)</b>	\$	\$	\$	24

Facility Name: **QUINCY SENIOR AND FAMILY RESOURCE**

Report Period Beginning:

Ending:

**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	<b>TOTAL</b>				\$			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**

	Name of Lender	2		Purpose of Loan	Date of Note	6		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		Related**				Amount of Note					
		YES	NO			Original	Balance				
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1					/ /	\$	\$	/ /		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
	<b>Working Capital</b>										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$	\$			\$	7
	<b>B. Non-Facility Related</b>										
8					/ /			/ /			8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	\$			\$	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: **QUINCY SENIOR AND FAMILY RESOURCE**

Report Period Beginning:

Ending:

**XI. BALANCE SHEET - Unrestricted Operating Fund.**

As of \_\_\_\_\_

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 96,397	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	18,482		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,371		7
8	Accounts Receivable (owners or related parties)	133,391		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 260,641	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,920,363		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	164,345		16
17	Accumulated Depreciation (book methods)	(2,039,223)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	166,334		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <b>UNAMORTIZED MORTGAGE L</b>	473,842		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 5,685,661	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,946,302	\$	25

\*(See instructions.)

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 32,504	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,397		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 68,901	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	900,233		38
39	Mortgage Payable	4,025,805		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42	<b>DEVELOPMENT FEE</b>	122,629		42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 5,048,667	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 5,117,568	\$	45
46	<b>TOTAL EQUITY</b>	\$ 828,734	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 5,946,302	\$	47

Facility Name: QUINCY SENIOR AND FAMILY RESOURCE

Report Period Beginning:

Ending:

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 700,104	1
2	Discounts and Allowances	20,893	2
<b>SUBTOTAL Resident Care</b>			
3	(line 1 minus line 2)	\$ 720,997	3
<b>B. Other Operating Revenue</b>			
4	Special Services	793,745	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		9
10	Laundry		10
<b>SUBTOTAL OTHER OPERATING REVENUE</b>			
11	(sum of lines 4 thru 10)	\$ 793,745	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
<b>SUBTOTAL Non-Operating Revenue</b>			
14	(sum of lines 12 and 13)	\$	14
<b>D. Other Revenue (specify):</b>			
15			15
16			16
<b>SUBTOTAL Other Revenue</b>			
17	(sum of lines 15 and 16)	\$	17
<b>TOTAL REVENUE</b>			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,514,742	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	484,653	19
20	Health Care/ Personal Care	432,060	20
21	General Administration	396,570	21
<b>B. Capital Expense</b>			
22	Ownership	659,576	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
<b>TOTAL EXPENSES</b>			
28	(sum of lines 19 thru 27)	\$ 1,972,859	28
<b>Income Before Income Taxes</b>			
29	(line 18 minus line 28)	\$ (458,117)	29
<b>Income Taxes</b>			
30		\$	30
<b>NET INCOME OR LOSS FOR THE YEAR</b>			
31	(line 29 minus line 30)	\$ (458,117)	31

CENTER EXPENSES

Column 5

Cable Television Expenses

, Column 3

Mortgage Premium Insurance 20,193

Amortization 20,393