

		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:** 1000064

**Facility Name:** Village at Morse Farm

**Address:** 1050 West Main Street Carlinville 62626  
Number City Zip Code

**County:** Macoupin

**Telephone Number:** ( 217 ) 854-8142 Fax # 217 854-9600

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

**Date Current Owners were Certified:** 6/26/2006

**Type of Ownership:**

<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	_____

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

**Name:** Michael McKeon **Telephone Number:** 217-854-8606  
**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 10/1/2009 to 9/30/2010 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) _____	(Date) _____
	(Type or Print Name) <u>Margaret Barkley</u>	
	(Title) <u>Chief Executive Officer</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Michael J. McKeon</u> <u>President</u>	
	(Firm Name & Address) <u>McKeon and Company, Inc.</u> <u>117 Greentree court, O'Fallon, Ill. 62269</u>	
	(Telephone) <u>618 791-6527</u> Fax <u>618-628-6949</u>	

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 Village at Morse Farm

Report Period Beginning: 10/1/2009 Ending: 9/30/2010

**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	14,235	1
2	7	Double Unit Apartment	7	2,555	2
3		Other		730	3
4	46	TOTALS	46	17,520	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	2,409	10,794		13,203	5
6	Double Unit	153	2,370		2,523	6
7	Other		552		552	7
8	TOTALS	2,562	13,716		16,278	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.91%

D. Indicate the number of paid bed-hold days the SLF had during this year 31 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)

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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: 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: Village at Morse Farm

Report Period Beginning:

10/1/2009

Ending:

9/30/2010

## 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	67,947	90,166		158,114		158,114	1
2	Housekeeping, Laundry and Maintenance	27,604	6,153	32,457	66,214		66,214	2
3	Heat and Other Utilities			44,748	44,748		44,748	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>95,551</b>	<b>96,319</b>	<b>77,206</b>	<b>269,076</b>		<b>269,076</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	92,869			92,869		92,869	6
7	Activities and Social Services			8,978	8,978		8,978	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>92,869</b>		<b>8,978</b>	<b>101,847</b>		<b>101,847</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	59,639		69,129	128,769		128,769	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			45,315	45,315		45,315	12
13	Insurance-Property, Liability and Malpractice			38,557	38,557		38,557	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>59,639</b>		<b>153,002</b>	<b>212,641</b>		<b>212,641</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>248,060</b>	<b>96,319</b>	<b>239,185</b>	<b>583,564</b>		<b>583,564</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			128,983	128,983		128,983	17
18	Interest			395,995	395,995		395,995	18
19	Real Estate Taxes			288	288		288	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Refinancing of Property			260,890	260,890		260,890	22
23	<b>TOTAL Ownership</b>			<b>786,155</b>	<b>786,155</b>		<b>786,155</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>248,060</b>	<b>96,319</b>	<b>1,025,341</b>	<b>1,369,720</b>		<b>1,369,720</b>	<b>24</b>

Facility Name: Village at Morse Farm

Report Period Beginning: 10/1/2009 Ending: 9/30/2010

**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	3	13.35	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	16.70	6
7	Cook Helpers/Assistants	2	12.53	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	11.78	10
11	Laundry			11
12	Managers	1	16.58	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other Assistant Msnager	1	12.02	16
17	<b>Total (lines 1 thru 16)</b>	<b>9</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>

**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
Macoupin Co H A		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).

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

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$</b>
		<b>3</b>

Facility Name: Village at Morse Farm

Report Period Beginning:

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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	\$ 4,970,024	\$ 124,250	40	\$ 124,250	\$	\$ 470,770	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	TOTAL (lines 1 thru 16)				\$ 4,970,024	\$ 124,250		\$ 124,250	\$	\$ 470,770	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	\$ 26,152	\$ 4,733	\$ 10,424	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 26,152	\$ 4,733	\$ 10,424	24

Facility Name: Village at Morse Farm

Report Period Beginning: 10/1/2009

Ending: 9/30/2010

**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	<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**

	1	Name of Lender	2		3	4	6		7	8	9						
			Related**				Purpose of Loan	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
			YES	NO									Original	Balance			
		<b>A. Directly Facility Related</b>															
		<b>Long-Term</b>															
1		Lancaster-Pollard		X	Mortgage	3/24/10	\$ 5,236,000	\$ 5,207,249	4/1/45	4.8700	\$ 127,206	1					
2		Midland States Bank		X	Mortgage	6/8/07	3,992,553	Zero	6/8/12	6.0000	133,213	2					
3		Dietzen Development		X	Mortgage	7/9/07	1,134,132	Zero	10/9/09	7.0000	135,576	3					
		<b>Working Capital</b>															
4						/ /			/ /			4					
5						/ /			/ /			5					
6						/ /			/ /			6					
7		<b>TOTAL Facility Related</b>					\$ 10,362,685	\$ 5,207,249			\$ 395,995	7					
		<b>B. Non-Facility Related</b>															
8						/ /			/ /			8					
9						/ /			/ /			9					
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 10,362,685	\$ 5,207,249			\$ 395,995	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: Village at Morse Farm

Report Period Beginning: 10/1/2009

Ending:

9/30/2010

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2010

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 292,653	\$	1
2	Cash-Patient Deposits	47,500		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	13,689		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	168,095		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 521,937	\$	10
	<b>B. Long-Term Assets</b>			
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	26,152		16
17	Accumulated Depreciation (book methods)	(481,194)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,593,537	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,115,474	\$	25

\*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 5,900	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,500		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,163		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation	4,995		33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	Deferred Revenues	21,703		35
36	Current Portion of LT Debt	59,642		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 141,903	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,147,607		39
40	Bonds Payable			40
41	Deferred Compensation	7,682		41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 5,155,289	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 5,297,192	\$	45
46	<b>TOTAL EQUITY</b>	\$ (181,718)	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 5,115,474	\$	47

Facility Name: Village at Morse Farm

Report Period Beginning: 10/1/2009

Ending:

9/30/2010

## 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	\$ 1,132,276	1
2	Discounts and Allowances		2
<b>SUBTOTAL Resident Care</b>			
3	(line 1 minus line 2)	\$ 1,132,276	3
<b>B. Other Operating Revenue</b>			
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	12,656	9
10	Laundry		10
<b>SUBTOTAL OTHER OPERATING REVENUE</b>			
11	(sum of lines 4 thru 10)	\$ 12,656	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	285	13
<b>SUBTOTAL Non-Operating Revenue</b>			
14	(sum of lines 12 and 13)	\$ 285	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)	\$ 1,145,217	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	422,255	19
20	Health Care/ Personal Care	293,718	20
21	General Administration	128,769	21
<b>B. Capital Expense</b>			
22	Ownership	524,977	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)	\$ 1,369,719	28
<b>Income Before Income Taxes</b>			
29	(line 18 minus line 28)	\$ (224,502)	29
<b>Income Taxes</b>			
30		\$	30
<b>NET INCOME OR LOSS FOR THE YEAR</b>			
31	(line 29 minus line 30)	\$ (224,502)	31