

		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: 1000064

Facility Name: Village at Morse Farm

Address: 1050 West Main St Carlinville 62626

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:

VOLUNTARY, NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

X

GOVERNMENTAL

State

County

X Other

Municipal

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

Name: Margaret Barkley Telephone Number: (217) 854-8142

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 10/1/15 to 9/30/16 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)

(Type or Print Name) Margaret Barkely

(Title) Chief Executive Officer

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () 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

HFS 3745C (N-4-05)

IL478-2471

Facility Name **Village at Morse Farm**

Report Period Beginning: 10/1/15 **Ending:** 9/30/16

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			3		
4	46	TOTALS	46	16,790	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	1,311	12,505		13,816	5
6	Double Unit		1,772		1,772	6
7	Other					7
8	TOTALS	1,311	14,277		15,588	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.84%

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

12 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. 24 (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

ACCUAL	☒	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.

STATE OF ILLINOIS

Facility Name: Village at Morse Farm

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10/1/15

Ending:

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9/30/16

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	41,630	115,512		157,142		157,142	1
2	Housekeeping, Laundry and Maintenance	44,510	18,131	27,289	89,930		89,930	2
3	Heat and Other Utilities			58,176	58,176	(14,135)	44,041	3
4	Other (specify):			2,992	2,992		2,992	4
5	TOTAL General Services	86,140	133,643	88,457	308,240	(14,135)	294,105	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	94,609	14,928		109,537		109,537	6
7	Activities and Social Services			6,707	6,707		6,707	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	94,609	14,928	6,707	116,244		116,244	9
	C. General Administration							
10	Administrative and Clerical	128,688	18,600	28,275	175,563		175,563	10
11	Marketing Materials, Promotions and Advertising		11,111	847	11,958		11,958	11
12	Employee Benefits and Payroll Taxes			80,543	80,543		80,543	12
13	Insurance-Property, Liability and Malpractice			70,474	70,474		70,474	13
14	Other (specify):							14
15	TOTAL General Administration	128,688	29,711	180,139	338,538		338,538	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	309,437	178,282	275,303	763,022	(14,135)	748,887	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			135,441	135,441		135,441	17
18	Interest			199,032	199,032		199,032	18
19	Real Estate Taxes			104,244	104,244		104,244	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			438,717	438,717		438,717	23
24	GRAND TOTAL (Sum of lines 16 and 23)	309,437	178,282	714,020	1,201,739	(14,135)	1,187,604	24

Facility Name: Village at Morse Farm

Report Period Beginning 10/1/15 Ending: 9/30/16

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	22.71	2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	13.62	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	9.69	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other Assistant Manager	1	15.05	16
17	Total (lines 1 thru 16)	4	\$	17

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

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

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).

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VIII. OWNERSHIP COSTS

A. Purchase price of land 80,055 Year land was acquired 1981 & 2012

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			2002	2006	\$ 4,970,024	\$ 124,317	40	\$ 124,317	\$	\$ 1,216,340	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Sprinkler System			2012	113,734	5,687	20	5,687		23,695	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)				\$ 5,083,758	\$ 130,004		\$ 130,004	\$	\$ 1,240,035	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	\$ 83,431	\$ 5,437	\$ 5,437	\$	5	\$ 72,980	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 83,431	\$ 5,437	\$ 5,437	\$		\$ 72,980	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

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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	Lancaster Pollard		X	Mortgage	3/24/10	\$ 5,236,000	\$ 4,958,607	4/1/45	3.9800	\$ 199,032	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 5,236,000	\$ 4,958,607			\$ 199,032	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 5,236,000	\$ 4,958,607			\$ 199,032	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.

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/16

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 405,222	\$	1
2	Cash-Patient Deposits	39,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	59,234		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,260		6
7	Other Prepaid Expenses	348		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Illinois Housing Development Auth</u>	69,821		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 575,885	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	80,055		13
14	Buildings, at Historical Cost	4,972,024		14
15	Leasehold Improvements, at Historical Cost	113,734		15
16	Equipment, at Historical Cost	83,431		16
17	Accumulated Depreciation (book methods)	(1,313,015)		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)	\$ 3,936,229	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,512,114	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 32,551	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,000		28
29	Short-Term Notes Payable	95,101		29
30	Accrued Salaries Payable	7,109		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	16,446		32
33	Deferred Compensation	1,283		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Unearned revenue (prepaid rent)</u>	8,250		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 199,740	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	4,863,506		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation	5,133		41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 4,868,639	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,068,379	\$	45
46	TOTAL EQUITY	\$ (556,265)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,512,114	\$	47

*(See instructions.)

Facility Name: Village at Morse Farm

Report Period Beginning: 10/1/15

Ending:

9/30/16

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

		1	
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,096,402	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,096,402	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	4,846	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 4,846	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	11	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 11	14
	D. Other Revenue (specify):		
15	Food Stamp Income	5,510	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 5,510	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,106,769	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	308,240	19
20	Health Care/ Personal Care	116,244	20
21	General Administration	338,538	21
	B. Capital Expense		
22	Ownership	438,717	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)	\$ 1,201,739	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (94,970)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (94,970)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$	32
33	Private Pay - Net Inpatient Revenue		33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$	37