

		FOR BHF USE			

LL2

Supportive Living Facility

2019

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2019)

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

Number City Zip Code

County: Macoupin

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

Federal Employer ID Number:

Date Current Owners were Certified: 6/26/06

Type of Ownership:

☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☒	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☐	Corporation	☒	Other
		☐	"Sub-S" Corp.		Municipal
		☐	Limited Liability Co.		
		☐	Trust		
		☐	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 10/1/18 to 9/30/19 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)	Margaret Barkley	
Paid Preparer	(Title)	Chief Executive Officer	
	(Signed)		(Date)
	(Print Name and Title)		
	(Firm Name & Address)		
	(Telephone)	()	Fax # ()

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

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

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 Village at Morse Farm Report Period Beginning: 10/1/18 Ending: 9/30/19

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	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	1,796	12,271		14,067	5
6	Double Unit		1,285		1,285	6
7	Other					7
8	TOTALS	1,796	13,556		15,352	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 91.44%

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

18 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. 31 (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

ACCRAUAL ☒ 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 principal? _____
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 principal? _____
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 principal? _____
If no, explain. _____

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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	48,992	101,197		150,189		150,189	1
2	Housekeeping, Laundry and Maintenance	52,379	21,502	30,740	104,621		104,621	2
3	Heat and Other Utilities			44,370	44,370		44,370	3
4	Other (specify):			976	976		976	4
5	TOTAL General Services	101,371	122,699	76,086	300,156		300,156	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	111,351	4,280		115,631		115,631	6
7	Activities and Social Services			7,196	7,196		7,196	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	111,351	4,280	7,196	122,827		122,827	9
	C. General Administration							
10	Administrative and Clerical	151,528	37,211	42,165	230,904		230,904	10
11	Marketing Materials, Promotions and Advertising		5,152	102	5,254		5,254	11
12	Employee Benefits and Payroll Taxes			102,074	102,074		102,074	12
13	Insurance-Property, Liability and Malpractice			68,196	68,196		68,196	13
14	Other (specify):			17,788	17,788		17,788	14
15	TOTAL General Administration	151,528	42,363	230,325	424,216		424,216	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	364,250	169,342	313,607	847,199		847,199	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			147,818	147,818		147,818	17
18	Interest			187,423	187,423		187,423	18
19	Real Estate Taxes			61,292	61,292		61,292	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			396,533	396,533		396,533	23
24	GRAND TOTAL (Sum of lines 16 and 23)	364,250	169,342	710,140	1,243,732		1,243,732	24

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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
3	Certified Nurse Assistants	6	10.72	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	13.00	6
7	Cook Helpers/Assistants	2	9.67	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	10.08	10
11	Laundry			11
12	Managers	1	23.62	12
13	Other Administrative	5	8.90	13
14	Clerical			14
15	Marketing			15
16	Other Assistant Manager	1	15.65	16
17	Total (lines 1 thru 16)	18	\$	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

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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? \$

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. (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

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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	\$ 4,972,024	124,650	40	\$ 124,650	\$	\$ 1,590,292	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Sprinkler System		2012		113,734	5,687	20	5,687		40,754	6
7	Sprinkler Revisions		2017		12,292	615	20	615		1,280	7
8	Sprinkler System		2018		231,410	11,571	20	11,571		14,464	8
9	Sprinkler Revisions		2018		5,484	274	20	274		503	9
10	Sprinkler Revisions		2018		4,995	250	20	250		250	10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 5,339,939	\$ 143,047		\$ 143,047	\$	\$ 1,647,543	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	\$ 101,275	\$ 4,771	\$ 4,771	\$	5	\$ 84,339	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 101,275	\$ 4,771	\$ 4,771	\$		\$ 84,339	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	\$ 4,661,582	4/1/45	3.9800	\$ 187,423	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 5,236,000	\$ 4,661,582			\$ 187,423	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 5,236,000	\$ 4,661,582			\$ 187,423	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 9/30/19

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 147,688	\$	1
2	Cash-Patient Deposits	44,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,809		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Illinois Hsg Developmt Auth	7,221		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 200,718	\$	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	367,915		15
16	Equipment, at Historical Cost	101,275		16
17	Accumulated Depreciation (book methods)	(1,731,882)		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)	\$ 3,789,387	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,990,105	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 48,307	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,000		28
29	Short-Term Notes Payable	107,141		29
30	Accrued Salaries Payable	11,086		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	15,461		32
33	Deferred Compensation	1,420		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 227,415	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	4,554,441		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation	5,679		41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 4,560,120	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,787,535	\$	45
46	TOTAL EQUITY	\$ (797,430)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 3,990,105	\$	47

*(See instructions.)

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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	\$ 1,143,024	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,143,024	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	5,619	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 5,619	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	159	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 159	14
	D. Other Revenue (specify):		
15	Food Stamp Income	616	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 616	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,149,418	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	300,156	19
20	Health Care/ Personal Care	122,827	20
21	General Administration	424,216	21
	B. Capital Expense		
22	Ownership	396,533	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)	\$ 1,243,732	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (94,314)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (94,314)	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