

		FOR BHF USE			

LL2

Supportive Living Facility

**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2011)**

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. Facility ID Number: <u>1000022</u></p> <p>Facility Name: <u>QUINCY SENIOR AND FAMILY RESOURCE CTR</u></p> <p>Address: <u>639 YORK STREET</u> <u>QUINCY</u> <u>62301</u> <small>Number City Zip Code</small></p> <p>County: <u>ADAMS</u></p> <p>Telephone Number: (<u>217</u>) <u>592-3668</u> Fax # (<u>217</u>) <u>592-3732</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>04/04/2003</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 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 checked="" 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 type="checkbox"/> Other _____</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>TODD SHACKELFORD</u> Telephone Number: (<u>217</u>) <u>223-7904</u> Email Address: _____</p>	<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	_____	<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>1/1/2011</u> to <u>12/31/2011</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%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>Todd Shackelford</u> (Title) <u>General and Managing Partner</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____ </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>Todd Shackelford</u> (Title) <u>General and Managing Partner</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____																												

Facility Name QUINCY SENIOR AND FAMILY RESOURCE CTR

Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	13,612	1,349		14,961	5
6	Double Unit	3,023	1,379		4,402	6
7	Other					7
8	TOTALS	16,635	2,728		19,363	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.07%

D. Indicate the number of paid bed-hold days the SLF had during this year 284 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 15 (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: 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 CTR

Report Period Beginning:

1/1/2011

Ending: 12/31/2011

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		215,776		215,776		215,776	1
2	Housekeeping, Laundry and Maintenance	36,879	90,560	22,290	149,729		149,729	2
3	Heat and Other Utilities			83,901	83,901	(11,153)	72,748	3
4	Other (specify):							4
5	TOTAL General Services	36,879	306,336	106,191	449,406	(11,153)	438,253	5
B. Health Care and Programs								
6	Health Care/ Personal Care	403,970	10,322		414,293		414,293	6
7	Activities and Social Services		13,984	26,162	40,146		40,146	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	403,970	24,307	26,162	454,439		454,439	9
C. General Administration								
10	Administrative and Clerical	58,180	3,978	114,422	176,581		176,581	10
11	Marketing Materials, Promotions and Advertising			10,574	10,574		10,574	11
12	Employee Benefits and Payroll Taxes	172,225			172,225		172,225	12
13	Insurance-Property, Liability and Malpractice	23,855			23,855		23,855	13
14	Other (specify):							14
15	TOTAL General Administration	254,261	3,978	124,996	383,235		383,235	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	695,110	334,621	257,349	1,287,080	(11,153)	1,275,927	16
Capital Expenses								
D. Ownership								
17	Depreciation			253,783	253,783		253,783	17
18	Interest			344,925	344,925		344,925	18
19	Real Estate Taxes			155	155		155	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): MORTGAGE INSURANCE PREMIUM & AMORTIZATION			40,440	40,440		40,440	22
23	TOTAL Ownership			639,304	639,304		639,304	23
24	GRAND TOTAL (Sum of lines 16 and 23)	695,110	334,621	896,653	1,926,384	(11,153)	1,915,231	24

Facility Name: QUINCY SENIOR AND FAMILY RESOURCE CTR

Report Period Beginning 1/1/2011 Ending: 12/31/2011

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 20.00	1
2	Licensed Practical Nurses	3	15.00	2
3	Certified Nurse Assistants	8	10.00	3
4	Activity Director & Assistants	1	8.75	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	2	8.50	10
11	Laundry	1	8.25	11
12	Managers	1	16.00	12
13	Other Administrative	2	9.25	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	19	\$	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	WEST CENTRAL ILLINOIS AGENCY ON AGING	\$ 95,491 1
2		
		Total \$ 95,491 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 1	City 2
NDC EQUITY FUNDS IV	NEW YORK, NY
WEST CENTRAL ILLINOIS AREA AGENCY ON AGING	

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? \$ _____
 (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 CTR

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	\$		\$ 253,783	\$ 253,783	\$ 2,293,006	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)				\$ 7,006,426	\$		\$ 253,783	\$ 253,783	\$ 2,293,006	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		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

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

Report Period Beginning: **1/1/2011**

Ending: **2/31/2011**

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	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	Name of Lender	2		3	4	6		7	8	9		
			Related**				Purpose of Loan	Date of Note					Amount of Note
			YES	NO			Original	Balance					
		A. Directly Facility Related											
		Long-Term											
1						/ /	\$	\$	/ /		\$	1	
2						/ /			/ /			2	
3						/ /			/ /			3	
		Working Capital											
4						/ /			/ /			4	
5						/ /			/ /			5	
6						/ /			/ /			6	
7		TOTAL Facility Related						\$	\$			\$	7
		B. Non-Facility Related											
8						/ /			/ /			8	
9						/ /			/ /			9	
10		TOTALS (lines 7, 8 and 9)						\$	\$			\$	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 CTR

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (9,251)	\$	1
2	Cash-Patient Deposits	0		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	11,986		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	14,098		7
8	Accounts Receivable (owners or related parties)	432,309		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 449,141	\$	10
	B. Long-Term Assets			
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)	(2,293,006)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	143,244		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): UNAMORTIZED MORTGAGE LI	453,449		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,388,394	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,837,536	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 24,750	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	183,000		29
30	Accrued Salaries Payable	57,895		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			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)	\$ 265,645	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	940,233		38
39	Mortgage Payable	3,995,660		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	DEVELOPMENT FEE	122,629		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 5,058,522	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,324,167	\$	45
46	TOTAL EQUITY	\$	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,324,167	\$	47

*(See instructions.)

Facility Name: QUINCY SENIOR AND FAMILY RESOURCE CTR

Report Period Beginning: 1/1/2011

Ending:

12/31/2011

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	\$ 741,882	1
2	Discounts and Allowances	21,592	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 763,474	3
B. Other Operating Revenue			
4	Special Services	847,545	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
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 847,545	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,611,020	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	449,406	19
20	Health Care/ Personal Care	454,439	20
21	General Administration	383,235	21
B. Capital Expense			
22	Ownership	639,304	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)	\$ 1,926,384	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (315,364)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (315,364)	31

Row 3, Column 5

Cable Television Expenses

Row 22, Column 3

Mortgage Insurance Premium	20,047
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Amortization	20,393
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