

		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.

I. Facility ID Number: 1000095

Facility Name: Autumn Ridge

Address: 1000 Galeener Street Vienna 62995
Number City Zip Code

County: Johnson

Telephone Number: (618) 658-2775 Fax # 618 658-4303

Federal Employer ID Number:

Date Current Owners were Certified: 9-8-2008

Type of Ownership:

☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☒	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code 501 C 3		☐	Corporation	☐	Other
		☐	"Sub-S" Corp.		
		☐	Limited Liability Co.		
		☐	Trust		
		☐	Other		

In the event there are further questions about this report, please contact:
Name: Stephanie Newcomb-Whitehea Telephone Number: (618 658-2775
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 7/1/2010 to 6/30/2011 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) Larry W. Mizell

(Title) Executive Director

(Signed) (Date)

Paid Preparer (Print Name and Title) Nora Beth Hacker Financial Division Director

(Firm Name & Address) Family Counseling Center, Inc. P.O. Box 759, Golconda, IL 62938

(Telephone) 618) 683-2461 Fax 618-683-2066

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 Autumn Ridge Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	<u>39</u>	Single Unit Apartment	<u>39</u>	<u>14,235</u>	1
2	<u>7</u>	Double Unit Apartment	<u>7</u>	<u>2,555</u>	2
3		Other			3
4	<u>46</u>	TOTALS	<u>46</u>	<u>16,790</u>	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	<u>7,818</u>	<u>3,429</u>		<u>11,247</u>	5
6	Double Unit	<u>438</u>	<u>1,642</u>		<u>2,080</u>	6
7	Other					7
8	TOTALS	<u>8,256</u>	<u>5,071</u>		<u>13,327</u>	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 79.37%

D. Indicate the number of paid bed-hold days the SLF had during this year 338 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 25 (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: 6/30/2011 Fiscal Year: 6/30/2011

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? Yes If yes, did the facility make all of the required payments of interest and principle? Yes
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: Autumn Ridge

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

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	62,634	72,047	6,730	141,411		141,411	1
2	Housekeeping, Laundry and Maintenance	102,829	13,220	26,366	142,415		142,415	2
3	Heat and Other Utilities			52,990	52,990		52,990	3
4	Other (specify): Waste Management			1,356	1,356		1,356	4
5	TOTAL General Services	165,463	85,267	87,442	338,172		338,172	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	27,725	464		28,189		28,189	6
7	Activities and Social Services		1,743		1,743		1,743	7
8	Other (specify): transportation			1,333	1,333		1,333	8
9	TOTAL Health Care and Programs	27,725	2,207	1,333	31,265		31,265	9
	C. General Administration							
10	Administrative and Clerical	93,788	3,895	13,158	110,841		110,841	10
11	Marketing Materials, Promotions and Advertising			20,289	20,289		20,289	11
12	Employee Benefits and Payroll Taxes	81,770			81,770		81,770	12
13	Insurance-Property, Liability and Malpractice			20,095	20,095		20,095	13
14	Other (specify): legal fees, loan fees, computer consultant, background checks, TB Tests			40,850	40,850		40,850	14
15	TOTAL General Administration	175,558	3,895	94,392	273,845		273,845	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	368,746	91,369	183,167	643,282		643,282	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			211,805	211,805		211,805	17
18	Interest			405,980	405,980		405,980	18
19	Real Estate Taxes			417	417		417	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			618,202	618,202		618,202	23
24	GRAND TOTAL (Sum of lines 16 and 23)	368,746	91,369	801,369	1,261,484		1,261,484	24

Facility Name: Autumn Ridge

Report Period Beginning 7/1/2010 Ending: 6/30/2011

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 17.44	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	5	8.25	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	15.14	6
7	Cook Helpers/Assistants	3	8.43	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	2	15.94	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	12	\$	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
Not Applicable			

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).

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	No payments made to owners, relatives and members of board of directors				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

Facility Name: Autumn Ridge

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

VIII. OWNERSHIP COSTS

A. Purchase price of land 189,716 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			2008	\$ 5,184,144	\$ 158,553	40	158,553	\$	\$ 510,980	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Land Improvements		2007	2007	242,216	12,111		12,111		39,161	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)				\$ 5,426,360	\$ 170,664		\$ 170,664	\$	\$ 550,141	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	\$ 274,184	\$ 27,419	\$ 27,419	\$	10	\$ 89,110	18
19	Vehicles	\$ 34,018	\$ 6,803	\$ 6,803	\$	5	\$ 21,545	19
20	TOTAL (lines 18 and 19)		\$ 34,222	\$ 34,222	\$		\$ 110,655	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: Autumn Ridge

Report Period Beginning: 7/1/2010 Ending: 6/30/20 6/30/2011

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Not Applicable

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	Peoples Bank		x	Building Construction	/ /	\$ 5,251,000	\$ 5,188,974	3/1/47	7.2500	\$ 382,427	1
2	USDA		x	Building Construction	/ /	1,018,324	1,005,950	3/1/48	1.0000	23,553	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 6,269,324	\$ 6,194,924			\$ 405,980	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 6,269,324	\$ 6,194,924			\$ 405,980	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.

STATE OF ILLINOIS

Page 7

Facility Name: Autumn Ridge

Report Period Beginning: 7/1/2010

Ending:

6/30/2011

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/11

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 313,366	\$	1
2	Cash-Patient Deposits	40,397		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	8,410		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,346		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 368,519	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	189,716		13
14	Buildings, at Historical Cost	4,994,428		14
15	Leasehold Improvements, at Historical Cost	242,216		15
16	Equipment, at Historical Cost	308,202		16
17	Accumulated Depreciation (book methods)	(660,796)		17
18	Deferred Charges	19,408		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): Capitalized Interest	218,382		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,311,556	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,680,075	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 16,516	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,777		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,163		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	28,741		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)	\$ 105,197	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	6,194,924		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 6,194,924	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 6,300,121	\$	45
46	TOTAL EQUITY	\$ (620,046)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,680,075	\$	47

*(See instructions.)

Facility Name: Autumn Ridge

Report Period Beginning: 7/1/2010

Ending:

6/30/2011

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

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,122,946	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,122,946	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	7,902	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 7,902	11
	C. Non-Operating Revenue		
12	Contributions/fund raiser	2,070	12
13	Interest and Other Investment Income	818	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,888	14
	D. Other Revenue (specify):		
15	storage building rental	3,178	15
16	USDA subsidy	37,151	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 40,329	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,174,065	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services		19
20	Health Care/ Personal Care		20
21	General Administration		21
	B. Capital Expense		
22	Ownership		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)	\$	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 1,174,065	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 1,174,065	31

