

		FOR BHF USE			

LL2

Supportive Living Facility

**2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2014)**

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>1000135</u></p> <p>Facility Name: <u>River to River Comm of Anna</u></p> <p>Address: <u>151 Denny Drive</u> <u>Anna</u> <u>62906</u> <small>Number City Zip Code</small></p> <p>County: <u>Union</u></p> <p>Telephone Number: (<u>618</u>) <u>993-7533</u> Fax # <u>618 993-7531</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10/27/2011</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 checked="" type="checkbox"/> Other <u>Disregarded Entity</u></td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>James Srna</u> Telephone Number: (<u>618</u>) <u>993-7533</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 checked="" type="checkbox"/> Other <u>Disregarded Entity</u>	_____	<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>1/1/14</u> to <u>12/31/14</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%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Sherry Barter-Hamlin</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CEO</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>David Schnake</u> <u>Partner</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Kerber, Eck & Braeckel LLP</u> <u>1116 W. Main St. Carbondale, IL 62901</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) (<u>618</u>) <u>529-1040</u> Fax # (<u>618</u>) <u>549-2311</u></td> <td></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) _____	(Date) _____		(Type or Print Name) <u>Sherry Barter-Hamlin</u>			(Title) <u>CEO</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>David Schnake</u> <u>Partner</u>			(Firm Name & Address) <u>Kerber, Eck & Braeckel LLP</u> <u>1116 W. Main St. Carbondale, IL 62901</u>			(Telephone) (<u>618</u>) <u>529-1040</u> Fax # (<u>618</u>) <u>549-2311</u>	
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Facility Name River to River Comm of Anna

Report Period Beginning: 1/1/14 Ending: 12/31/14

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	45	Single Unit Apartment	45	16,425	1
2	5	Double Unit Apartment	5	1,825	2
3		Other			3
4	50	TOTALS	50	18,250	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	9,256	6,911		16,167	5
6	Double Unit	730	1,095		1,825	6
7	Other					7
8	TOTALS	9,986	8,006		17,992	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.59%

D. Indicate the number of paid bed-hold days the SLF had during this year 256 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 58 (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: 2014 Fiscal Year: 2014

* 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: River to River Comm of Anna

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	68,949	116,548	1,048	186,545	(4,069)	182,476	1
2	Housekeeping, Laundry and Maintenance	35,724	13,363	16,199	65,286		65,286	2
3	Heat and Other Utilities			70,986	70,986		70,986	3
4	Other (specify):			7,702	7,702	(2,838)	4,864	4
5	TOTAL General Services	104,673	129,911	95,935	330,519	(6,907)	323,612	5
B. Health Care and Programs								
6	Health Care/ Personal Care	152,381	662	30,303	183,346		183,346	6
7	Activities and Social Services	30,386	1,877	2,525	34,788		34,788	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	182,767	2,539	32,828	218,134		218,134	9
C. General Administration								
10	Administrative and Clerical	64,346	15,109	186,164	265,619	(39,348)	226,271	10
11	Marketing Materials, Promotions and Advertising	6,155		6,412	12,567		12,567	11
12	Employee Benefits and Payroll Taxes			86,005	86,005		86,005	12
13	Insurance-Property, Liability and Malpractice			68,340	68,340		68,340	13
14	Other (specify):							14
15	TOTAL General Administration	70,501	15,109	346,921	432,531	(39,348)	393,183	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	357,941	147,559	475,684	981,184	(46,255)	934,929	16
Capital Expenses								
D. Ownership								
17	Depreciation			355,269	355,269	14,908	370,177	17
18	Interest			273,515	273,515		273,515	18
19	Real Estate Taxes			53,074	53,074		53,074	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			22,311	22,311		22,311	22
23	TOTAL Ownership			704,169	704,169	14,908	719,077	23
24	GRAND TOTAL (Sum of lines 16 and 23)	357,941	147,559	1,179,853	1,685,353	(31,347)	1,654,006	24

Facility Name: River to River Comm of Anna

Report Period Beginning 1/1/14

Ending: 12/31/14

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.5	\$ 22.60	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	12	8.65	3
4	Activity Director & Assistants			4
5	Social Service Workers	1	12.02	5
6	Head Cook			6
7	Cook Helpers/Assistants	4	8.94	7
8	Dishwashers			8
9	Maintenance Workers	1	9.00	9
10	Housekeepers	2	8.51	10
11	Laundry			11
12	Managers	1	13.87	12
13	Other Administrative	1	19.23	13
14	Clerical			14
15	Marketing	1	21.44	15
16	Other	1	9.02	16
17	Total (lines 1 thru 16)	24.5	\$ 133.28	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	\$	1
2		2
Total		\$ 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
Marion Supportive Living, LP		Marion, IL	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
River to River Corporation		Marion, IL		Managing Partner	
River to River Senior Services		Marion, IL		Service Provider	

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: River to River Senior Services, LLC If yes, what is the value of those services? \$ 84,958

(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: River to River Comm of Anna

Report Period Beginning:

1/1/14

Ending:

12/31/14

VIII. OWNERSHIP COSTS

A. Purchase price of land 200,000 Year land was acquired 3/31/2011

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	50			2011	\$ 7,792,677	\$ 283,232	27.5	\$ 283,232	\$	\$ 908,603	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Landscaping		2011		30,000	2,309	15	2,000	(309)	9,224	6
7	Walkway - Back & Front		2013		2,129	142	15	142		213	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)				\$ 7,824,806	\$ 285,683		\$ 285,374	\$ (309)	\$ 918,040	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	\$ 551,465	\$ 65,330	\$ 80,547	15,217	5	\$ 357,498	18
19	Vehicles					5	-	19
20	TOTAL (lines 18 and 19)		\$ 551,465	\$ 65,330	\$ 80,547		\$ 357,498	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: River to River Comm of Anna

Report Period Beginning: 1/1/14

Ending:

12/31/14

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 41,960	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	177,705		3
4	Supply Inventory (priced at)	13,604		4
5	Short-Term Investments			5
6	Prepaid Insurance	35,557		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)	\$ 268,826	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	160,000		13
14	Buildings, at Historical Cost	7,792,678		14
15	Leasehold Improvements, at Historical Cost	32,129		15
16	Equipment, at Historical Cost	568,404		16
17	Accumulated Depreciation (book methods)	(1,279,793)		17
18	Deferred Charges	382,430		18
19	Organization & Pre-Operating Costs	9,948		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,233)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred financing cost, net	1,230,231		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,892,794	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,161,620	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 59,852	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	53,467		31
32	Accrued Interest Payable			32
33	Deferred Compensation	701,704		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Insurance	7,040		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 822,063	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,510,528		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)	\$ 5,510,528	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 6,332,591	\$	45
46	TOTAL EQUITY	\$ 2,829,029	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,161,620	\$	47

*(See instructions.)

Facility Name: River to River Comm of Anna

Report Period Beginning: 1/1/14

Ending:

12/31/14

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	\$ 397,783	1
2	Discounts and Allowances	(14,806)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 382,977	3
B. Other Operating Revenue			
4	Special Services	69,544	4
5	Other Health Care Services	1,238,737	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	4,069	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 1,312,350	11
C. Non-Operating Revenue			
12	Contributions	990	12
13	Interest and Other Investment Income	1,704	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,694	14
D. Other Revenue (specify):			
15	Senior TV Fees	2,838	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 2,838	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,700,859	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	330,519	19
20	Health Care/ Personal Care	218,134	20
21	General Administration	432,531	21
B. Capital Expense			
22	Ownership	704,169	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)	\$ 1,685,353	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 15,506	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 15,506	31

Anna Supportive Living, L.P.
 Additional Information
 12/31/2014

Page 4 Section VII A.

Related Organization	Nature of Purchase	Facility Book Value	Actual Cost	Difference
Management Fee	Managing/Accounting	\$ 84,958	\$ 59,525	\$ (25,433)
Congregate Expense	Corporate Expenses	\$ 17,172	\$ 17,172	\$ -
Record Storage	Storage Fee	\$ 12,000	\$ 12,000	\$ -

Page 3 Section IV eliminations

Amount	Line #	
Guest Meals	Line 1	Account 4600
Senior TV	Line 4	Account 4081
Admin & General	Line 10	See above
Admin & General - Bad debt	Line 10	Account 9010
Accelerated Depreciation	Line 17	Schedule VIII
<u>Total</u>		
<u>(31,347)</u>		

Page 3 Section IV Line 4

Trash	3,879
TV	3,823
<u>Total</u>	<u>7,702</u>

Page 3 Section IV Line 22

Amortization of Bond Cost	7,333
Amortization of Tax Credit Fees	995
Amortization of Asset Management Fee	12,733
Tax Credit Fees	1,250
<u>Total</u>	<u>22,311</u>

