

		FOR BHF USE			

LL2

Supportive Living Facility

**2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2008)**

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.</p> <p>Facility Name: <u>Autumn Ridge</u></p> <p>Address: <u>1000 Galeener Street</u> <u>Vienna</u> <u>62995</u> <small>Number City Zip Code</small></p> <p>County: <u>Johnson</u></p> <p>Telephone Number: (<u>618</u>) <u>658-2775</u> Fax # <u>618 658-4303</u></p> <p>Federal Employer ID Number: <u>37-6147532</u></p> <p>Date Current Owners were Certified: <u>4-15-08</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" 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 type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 C 3</u></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>Stephanie Newcomb-Whitehea</u> Telephone Number: (<u>618 658-2775</u>) Email Address: <u>stephanie@arslf.com</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 C 3</u>	<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>4-15-08</u> to <u>6/30/08</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>Larry W. Mizell</u> (Title) <u>Executive Director.</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>Nora Beth Hacker Financial Division Director</u> (Firm Name & Address) <u>Family Counseling Center, Inc. P.O. Box 759, Golconda, IL 62938</u> (Telephone) <u>618-683-2461</u> Fax <u>618-683-2066</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>Larry W. Mizell</u> (Title) <u>Executive Director.</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Nora Beth Hacker Financial Division Director</u> (Firm Name & Address) <u>Family Counseling Center, Inc. P.O. Box 759, Golconda, IL 62938</u> (Telephone) <u>618-683-2461</u> Fax <u>618-683-2066</u>
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Facility Name Autumn Ridge

Report Period Beginning: 4-15-08 Ending: 6/30/08

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	29	2,525	1
2	7	Double Unit Apartment	7	532	2
3		Other			3
4	46	TOTALS	36	3,057	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	270	208		478	5
6	Double Unit					6
7	Other					7
8	TOTALS	270	208		478	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 15.64%

D. Indicate the number of paid bed-hold days the SLF had during this year
None Also, indicate the number of unpaid bed-hold days the SLF had during this year. None **(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: 06/30/08 Fiscal Year: 06/30/08

* 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:

4-15-08

Ending:

6/30/08

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	29,240	18,610	486	48,336		48,336	1
2	Housekeeping, Laundry and Maintenance	10,142	9,579		19,721		19,721	2
3	Heat and Other Utilities			24,901	24,901	(2,156)	22,745	3
4	Other (specify): Waste Mgt			292	292		292	4
5	TOTAL General Services	39,382	28,189	25,679	93,250	(2,156)	91,094	5
B. Health Care and Programs								
6	Health Care/ Personal Care	2,254	16	3,463	5,733		5,733	6
7	Activities and Social Services	2,854	3,394		6,248		6,248	7
8	Other (specify): transportation			1,261	1,261		1,261	8
9	TOTAL Health Care and Programs	5,108	3,410	4,724	13,242		13,242	9
C. General Administration								
10	Administrative and Clerical	27,755	42,503	11,391	81,649		81,649	10
11	Marketing Materials, Promotions and Advertising	2,854		4,981	7,835		7,835	11
12	Employee Benefits and Payroll Taxes	9,035			9,035		9,035	12
13	Insurance-Property, Liability and Malpractice			11,272	11,272		11,272	13
14	Other (specify): legal fees, loan fees, computer consultant, background checks, TB tests			24,472	24,472		24,472	14
15	TOTAL General Administration	39,644	42,503	52,116	134,263		134,263	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	84,134	74,102	82,519	240,755	(2,156)	238,599	16
Capital Expenses								
D. Ownership								
17	Depreciation							17
18	Interest			1,101	1,101		1,101	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): USDA Loan fee			21,937	21,937		21,937	22
23	TOTAL Ownership			23,038	23,038		23,038	23
24	GRAND TOTAL (Sum of lines 16 and 23)	84,134	74,102	105,557	263,793	(2,156)	261,637	24

Facility Name: Autumn Ridge

Report Period Beginning 4-15-08 Ending: 6/30/08

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			2
3	Certified Nurse Assistants	5	8.00	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	12.69	6
7	Cook Helpers/Assistants	3	8.24	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	3	12.01	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	12	\$	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	
No payments made to owners, relatives and members of board of directors.					
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 <u>1</u>	City <u>2</u>
Not Applicable.	

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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: Autumn Ridge

Report Period Beginning: 4-15-08

Ending: 6/30/08

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	\$ 5,249,617	\$	40	\$	\$	\$	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)				\$ 5,249,617	\$		\$	\$	\$	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	\$ 65,101	\$	\$	\$	10	\$	18
19	Vehicles	\$ 34,018	\$	\$	\$	5	\$	19
20	TOTAL (lines 18 and 19)	\$ 99,119	\$	\$	\$		\$	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: 4-15-08

Ending: 6/30/08

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	
		Related**				Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Date of Note	Original	Balance	Maturity Date			
A. Directly Facility Related Long-Term											
1	Peoples Bank		x	Building Construction	/ /	\$ 5,251,000	\$ 5,251,000	3/1/47	7.2500	\$ 1,101	1
2	USDA		x	Building Construction	/ /	1,000,000	1,000,000	3/1/48	1.0000		2
3					/ /			/ /			3
Working Capital											
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 6,251,000	\$ 6,251,000			\$ 1,101	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 6,251,000	\$ 6,251,000			\$ 1,101	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

Facility Name: Autumn Ridge

Report Period Beginning: 4-15-08

Ending:

6/30/08

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/08

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 427,289	\$	1
2	Cash-Patient Deposits	8,022		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	13,283		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,515		6
7	Other Prepaid Expenses	3,923		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 460,032	\$	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	4,869,340		14
15	Leasehold Improvements, at Historical Cost	238,523		15
16	Equipment, at Historical Cost	240,872		16
17	Accumulated Depreciation (book methods)			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): Capitalized Interest	299422		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,837,873	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,297,905	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 22,610	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	7,779		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation	9,002		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)	\$ 39,391	\$	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable	6,251,000		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)	\$ 6,251,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 6,290,391	\$	45
46	TOTAL EQUITY	\$ 7,514	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,297,905	\$	47

*(See instructions.)

Facility Name: Autumn Ridge

Report Period Beginning: 4-15-08

Ending:

6/30/08

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

	1	Amount	
Revenue			
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 35,546	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 35,546	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	2,211	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 2,211	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	5,743	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 5,743	14
D. Other Revenue (specify):			
15	Storage Building rental	74	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 74	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 43,574	18

	2	Amount	
Expenses			
A. Operating Expenses			
19	General Services	91,094	19
20	Health Care/ Personal Care	13,242	20
21	General Administration	134,263	21
B. Capital Expense			
22	Ownership	23,038	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)	\$ 261,637	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (218,063)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (218,063)	31