

		FOR BHF USE					

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**Supportive Living Facility**

**2009  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2009)**

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 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: 37-6147532

Date Current Owners were Certified: 9-8-08

Type of Ownership:

<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 _____	

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2008 to 6/30/2009 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

Paid Preparer

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(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

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

Name: Stephanie Newcomb-Whitehea Telephone Number: ( 618 658-2775 )  
Email Address: stephanie@arslf.com

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: 7/1/2008 Ending: 6/30/2009

**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 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	3,186	4,026		7,212	5
6	Double Unit		801		801	6
7	Other					7
8	TOTALS	3,186	4,827		8,013	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 47.72%

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

139 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)

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H. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

I. Is your fiscal year identical to your tax year?  YES  NO

Tax Year: 6/30/2009 Fiscal Year: 6/30/2009

\* 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:

7/1/2008

Ending:

6/30/2009

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	75,559	39,159	5,225	119,943		119,943	1
2	Housekeeping, Laundry and Maintenance	122,868	2,588		125,456		125,456	2
3	Heat and Other Utilities			64,848	64,848		64,848	3
4	Other (specify): Waste Mgt			1,423	1,423		1,423	4
5	<b>TOTAL General Services</b>	<b>198,427</b>	<b>41,747</b>	<b>71,496</b>	<b>311,670</b>		<b>311,670</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	26,525	111	823	27,459		27,459	6
7	Activities and Social Services		959	6,669	7,628		7,628	7
8	Other (specify): transportation			904	904		904	8
9	<b>TOTAL Health Care and Programs</b>	<b>26,525</b>	<b>1,070</b>	<b>8,396</b>	<b>35,991</b>		<b>35,991</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	123,960	4,020	5,067	133,047		133,047	10
11	Marketing Materials, Promotions and Advertising			24,336	24,336		24,336	11
12	Employee Benefits and Payroll Taxes	30,714			30,714		30,714	12
13	Insurance-Property, Liability and Malpractice			13,271	13,271		13,271	13
14	Other (specify): legal fees, loan fees, computer consultant, background checks, TB tests			13,881	13,881		13,881	14
15	<b>TOTAL General Administration</b>	<b>154,674</b>	<b>4,020</b>	<b>56,555</b>	<b>215,249</b>		<b>215,249</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>379,626</b>	<b>46,837</b>	<b>136,447</b>	<b>562,910</b>		<b>562,910</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation							17
18	Interest			399,228	399,228		399,228	18
19	Real Estate Taxes			422	422		422	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>399,650</b>	<b>399,650</b>		<b>399,650</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>379,626</b>	<b>46,837</b>	<b>536,097</b>	<b>962,560</b>		<b>962,560</b>	<b>24</b>

Facility Name: Autumn Ridge

Report Period Beginning 7/1/2008

Ending:

6/30/2009

**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	<b>Total (lines 1 thru 16)</b>	<b>12</b>	<b>\$</b>	<b>17</b>

**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	
				<b>Total</b>	<b>\$</b>	<b>6</b>

**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).

Facility Name: Autumn Ridge

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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	\$		\$	\$	\$	1
2											2
3											3
4											4
5											5
	<b>Improvement Type</b>										
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	\$	\$	\$	20	\$ 33,249	18
19	Vehicles	34,018				5	15,000	19
20	TOTAL (lines 18 and 19)	\$ 99,119	\$	\$	\$		\$ 48,249	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: 7/1/2008

Ending: 6/30/2009

**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	<b>TOTAL</b>				\$			7

8. Is movable equipment rental included in building rental?  YES  NO

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				
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1	Peoples Bank		x	Building Construction	/ /	\$ 5,251,000	\$ 5,234,390	3/1/47	7.2500	\$ 378,872	1
2	USDA		x	Building Construction	/ /	1,018,324	1,014,764	3/1/48	1.0000	20,356	2
3					/ /			/ /			3
	<b>Working Capital</b>										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$ 6,269,324	\$ 6,249,154			\$ 399,228	7
	<b>B. Non-Facility Related</b>										
8					/ /			/ /			8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 6,269,324	\$ 6,249,154			\$ 399,228	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: Autumn Ridge

Report Period Beginning: 7/1/2008

Ending:

6/30/2009

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2009

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 45,797	\$	1
2	Cash-Patient Deposits	25,706		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	102,100		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,816		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 179,419	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	189,716		13
14	Buildings, at Historical Cost	5,143,202		14
15	Leasehold Improvements, at Historical Cost	242,216		15
16	Equipment, at Historical Cost	308,202		16
17	Accumulated Depreciation (book methods)	(48,249)		17
18	Deferred Charges	21,602		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): <b>Capitalized Interest</b>	236,945		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 6,093,634	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 6,273,053	\$	25

\*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 174,610	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,848		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,501		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36				36
37	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 36)	\$ 220,959	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	6,249,154		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities</b> (sum of lines 38 thru 43)	\$ 6,249,154	\$	44
45	<b>TOTAL LIABILITIES</b> (sum of lines 37 and 44)	\$ 6,470,113	\$	45
46	<b>TOTAL EQUITY</b>	\$ (197,060)	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 45 and 46)	\$ 6,273,053	\$	47

Facility Name: Autumn Ridge

Report Period Beginning: 7/1/2008

Ending:

6/30/2009

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 642,938	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 642,938</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
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	8,788	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 8,788</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions	937	12
13	Interest and Other Investment Income	2,768	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 3,705</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	storage building rental	1,223	15
16	USDA subsidy	23,314	16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 24,537</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 679,968</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	311,670	19
20	Health Care/ Personal Care	35,991	20
21	General Administration	215,249	21
<b>B. Capital Expense</b>			
22	Ownership	399,650	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 962,560</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (282,592)</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ (282,592)</b>	<b>31</b>