

		FOR BHF USE			

LL2

Supportive Living Facility

**2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2013)**

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>1000095</u></p> <p>Facility Name: <u>Autumn Ridge</u></p> <p>Address: <u>1000 Galeener St</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: _____</p> <p>Date Current Owners were Certified: <u>9-8-2008</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>501C3</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</u>) <u>658-2775</u> Email Address: _____</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>501C3</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>7/1/12</u> to <u>6/30/13</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:30%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td><u>9/25/2013</u></td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Larry W. Mizell</u></td> <td>(Date)</td> </tr> <tr> <td></td> <td>(Title) <u>Executive Director</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) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) () _____</td> <td>Fax # () _____</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) _____	<u>9/25/2013</u>		(Type or Print Name) <u>Larry W. Mizell</u>	(Date)		(Title) <u>Executive Director</u>		Paid Preparer	(Signed) _____	(Date)		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) () _____	Fax # () _____
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	(Telephone) () _____	Fax # () _____																																												

Facility Name Autumn Ridge

Report Period Beginning: 7/1/12 Ending: 6/30/13

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	9,624	3,428		13,052	5
6	Double Unit	74	1,486		1,560	6
7	Other					7
8	TOTALS	9,698	4,914		14,612	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 87.03%

D. Indicate the number of paid bed-hold days the SLF had during this year
265 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)

N/A

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

* 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? N/A

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? N/A

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? N/A

If no, explain. _____

Facility Name: Autumn Ridge

Report Period Beginning:

7/1/12

Ending:

6/30/13

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	63,466	84,532	7,477	155,475		155,475	1
2	Housekeeping, Laundry and Maintenance	110,261	5,937	32,587	148,785		148,785	2
3	Heat and Other Utilities			54,481	54,481		54,481	3
4	Other (specify): Waste management			1,278	1,278		1,278	4
5	TOTAL General Services	173,727	90,469	95,823	360,019		360,019	5
B. Health Care and Programs								
6	Health Care/ Personal Care	26,366	943		27,309		27,309	6
7	Activities and Social Services	12,765	2,611		15,376		15,376	7
8	Other (specify): Transportation			2,847	2,847		2,847	8
9	TOTAL Health Care and Programs	39,131	3,554	2,847	45,532		45,532	9
C. General Administration								
10	Administrative and Clerical	89,730	4,020		93,750		93,750	10
11	Marketing Materials, Promotions and Advertising			15,414	15,414		15,414	11
12	Employee Benefits and Payroll Taxes	93,772			93,772		93,772	12
13	Insurance-Property, Liability and Malpractice			19,835	19,835		19,835	13
14	Other (specify): legal fees, loan fees, computer consult, background cks, TB tests			43,796	43,796		43,796	14
15	TOTAL General Administration	183,502	4,020	79,045	266,567		266,567	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	396,360	98,043	177,715	672,118		672,118	16
Capital Expenses								
D. Ownership								
17	Depreciation			211,397	211,397		211,397	17
18	Interest			383,960	383,960		383,960	18
19	Real Estate Taxes			8,422	8,422		8,422	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			603,779	603,779		603,779	23
24	GRAND TOTAL (Sum of lines 16 and 23)	396,360	98,043	781,494	1,275,897		1,275,897	24

Facility Name: Autumn Ridge

Report Period Beginning 7/1/12

Ending:

6/30/13

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 18.14	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6	8.58	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	15.75	6
7	Cook Helpers/Assistants	4	8.64	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	11.33	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	13	\$	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 the board of directors						
1				\$	1	
2					2	
3					3	
4					4	
5					5	
				Total	\$	6

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: N/A 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:

7/1/12

Ending:

6/30/13

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		\$ 158,553	\$	\$ 828,087	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements		2007	242,216	11,869		11,869		63,382	6
7		Entrance Sign		2012	10,892	726	15	726		968	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)				\$ 5,437,252	\$ 171,148		\$ 171,148	\$	\$ 892,437	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	\$ 143,947	18
19	Vehicles	34,018	5,669	5,669		5	34,018	19
20	TOTAL (lines 18 and 19)	\$ 308,202	\$ 33,088	\$ 33,088	\$		\$ 177,965	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: 7/1/12

Ending: 6/30/13

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	\$ 5,127,708	3/1/47	6.9500	\$ 362,747
2	USDA		X	Building Construction	/ /	1,018,324	996,766	3/1/48	1.0000	21,213
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 6,269,324	\$ 6,124,474			\$ 383,960
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 6,269,324	\$ 6,124,474			\$ 383,960

* 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: 7/1/12

Ending:

6/30/13

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/13

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 508,830	\$	1
2	Cash-Patient Deposits	36,509		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	131,316		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)	\$ 683,001	\$	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	253,108		15
16	Equipment, at Historical Cost	514,207		16
17	Accumulated Depreciation (book methods)	(1,070,402)		17
18	Deferred Charges	17,946		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,899,003	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,582,004	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 7,682	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,399		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,393		30
31	Accrued Taxes Payable	1,638		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)	\$ 111,853	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	6,124,475		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)	\$ 6,124,475	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 6,236,328	\$	45
46	TOTAL EQUITY	\$ (654,324)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,582,004	\$	47

*(See instructions.)

Facility Name: Autumn Ridge

Report Period Beginning: 7/1/12

Ending:

6/30/13

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	\$ 1,240,901	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,240,901	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	3,341	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 3,341	11
C. Non-Operating Revenue			
12	Contributions/Fund Raiser	2,996	12
13	Interest and Other Investment Income	43	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 3,039	14
D. Other Revenue (specify):			
15	storage building rental	3,603	15
16	USDA subsidy	36,342	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 39,945	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,287,226	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	360,019	19
20	Health Care/ Personal Care	45,532	20
21	General Administration	266,567	21
B. Capital Expense			
22	Ownership	603,779	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)	\$ 1,275,897	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 11,329	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 11,329	31

