FOR BHF USE

LL2

Supportive Living Facility

2016

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)

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 (Number) Vienna (City) 62995 (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:

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

In the event there are further questions about this report, please contact:
Name: Bryan Throgmorton **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 7/1/15 to 6/30/16 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) 9/20/2016 (Date)
(Type or Print Name) Sherrie L. Crabb
(Title) Executive Director

Paid Preparer

(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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: 7/1/15 Ending: 6/30/16

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	7,872	3,955		11,827	5
6	Double Unit	553	1,724		2,277	6
7	Other					7
8	TOTALS	8,425	5,679		14,104	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 84.00%

D. Indicate the number of paid bed-hold days the SLF had during this year 137 **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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS
ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] 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: 7/1/15 Ending: 6/30/16**

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	55,983	94,164	4,315	154,462		154,462	1
2	Housekeeping, Laundry and Maintenance	104,636	4,541	24,544	133,721		133,721	2
3	Heat and Other Utilities			58,583	58,583		58,583	3
4	Other (specify):			1,793	1,793		1,793	4
5	**TOTAL General Services**	160,619	98,705	89,235	348,559		348,559	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	46,126	126	24	46,276		46,276	6
7	Activities and Social Services	22,789	2,375	1,322	26,486		26,486	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	68,915	2,501	1,346	72,762		72,762	9
	C. General Administration							
10	Administrative and Clerical	70,533	2,378		72,911		72,911	10
11	Marketing Materials, Promotions and Advertising			5,549	5,549		5,549	11
12	Employee Benefits and Payroll Taxes	92,151			92,151		92,151	12
13	Insurance-Property, Liability and Malpractice			20,035	20,035		20,035	13
14	Other (specify): Legal fees, loan fees, computer consultant, background cks, TB tests.			39,034	39,034		39,034	14
15	**TOTAL General Administration**	162,684	2,378	64,618	229,680		229,680	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	392,218	103,584	155,199	651,001		651,001	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			207,825	207,825		207,825	17
18	Interest			379,032	379,032		379,032	18
19	Real Estate Taxes			27,243	27,243		27,243	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			614,100	614,100		614,100	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	392,218	103,584	769,299	1,265,101		1,265,101	24

Facility Name: Autumn Ridge **Report Period Beginning: 7/1/15 Ending: 6/30/16**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 21.22	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	5	8.65	3
4	Activity Director & Assistants	1	12.87	4
5	Social Service Workers			5
6	Head Cook	1	20.84	6
7	Cook Helpers/Assistants	4	8.81	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	17.18	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 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				OTHER RELATED BUSINESS ENTITIES					
Name	1	City	2	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 [X]

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 [X]

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: 7/1/15 Ending: 6/30/16

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

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	$ 5,232,663	$ 166,421		$ 166,421	$	$ 1,357,899	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Land Improvements			2007	442,824	12,110		12,110		99,714	6
7	Entrance Sign			2012	10,892	727		727		3,147	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)				$ 5,686,379	$ 179,258		$ 179,258	$	$ 1,460,760	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	$ 28,567	$ 28,567	$	10	$ 227,352	18
19	Vehicles	34,018				5	34,018	19
20	TOTAL (lines 18 and 19)	$ 308,202	$ 28,567	$ 28,567	$		$ 261,370	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:** 7/1/15 **Ending:** 6/30/16

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 [X] NO

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 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 [X] 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 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1	Peoples Bank		X	Building Construction	/ /	$ 5,251,000	$ 5,006,402	3/1/47	6.9500	$ 355,402	1
2	USDA		X	Building Construction	/ /	1,018,324	980,379	3/1/48	1.0000	22,026	2
3	DeLage Financial		X	Lease Copier payable	/ /	9,861	8,257	12/28/20	9.5450	1,604	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 6,279,185	$ 5,995,038			$ 379,032	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 6,279,185	$ 5,995,038			$ 379,032	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:** 7/1/15 **Ending:** 6/30/16

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/16 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 639,914	$	1
2	Cash-Patient Deposits	35,744		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	90,855		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,346		6
7	Other Prepaid Expenses	36,337		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 809,196	$	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	5,232,663		14
15	Leasehold Improvements, at Historical Cost	253,108		15
16	Equipment, at Historical Cost	308,202		16
17	Accumulated Depreciation (book methods)	(1,708,858)		17
18	Deferred Charges	15,752		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)**	$ 4,290,583	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,099,779	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 34,984	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,744		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,020		30
31	Accrued Taxes Payable	2,138		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)**	$ 121,627	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	5,995,039		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)**	$ 5,995,039	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 6,116,666	$	45
46	**TOTAL EQUITY**	$ (1,016,886)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 5,099,780	$	47

***(See instructions.)**

Facility Name: Autumn Ridge **Report Period Beginning: 7/1/15 Ending: 6/30/16**

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,151,318	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,151,318	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	8,854	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 8,854	11
	C. Non-Operating Revenue		
12	Contributions	4,153	12
13	Interest and Other Investment Income	62	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 4,215	14
	D. Other Revenue (specify):		
15	**Storage Building Rental**	4,825	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 4,825	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,169,212	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	348,559	19
20	Health Care/ Personal Care	72,762	20
21	General Administration	229,680	21
	B. Capital Expense		
22	Ownership	614,100	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)**	$ 1,265,101	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (95,889)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (95,889)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 424,173	32
33	Private Pay - Net Inpatient Revenue	656,669	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) **SNAP/LINK**	34,147	35
36	Other-(specify) **USDA subsidy**	36,329	36
37	TOTAL (This total must agree to Line 3)	$ 1,151,318	37