FOR BHF USE

LL2

Supportive Living Facility

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)

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
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2016 to 6/30/2017 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) Sherrie L. Crabb

(Title) Executive Director

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

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

Name: Nora Beth Hacker Telephone Number: (618) 683-2471

Email Address:

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: 7/1/2016 Ending: 6/30/2017

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	7,515	6,809		14,324	5
6	Double Unit	124	1,247		1,371	6
7	Other					7
8	TOTALS	7,639	8,056		15,695	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.48%

D. Indicate the number of paid bed-hold days the SLF had during this year 123 **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)
None

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: 7/1/2016 Ending: 6/30/2017**

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	60,264	100,832	8,603	169,699		169,699	1
2	Housekeeping, Laundry and Maintenance	25,271	5,786	42,636	73,693		73,693	2
3	Heat and Other Utilities			54,366	54,366		54,366	3
4	Other (specify): Waste Managemetn			1,405	1,405		1,405	4
5	**TOTAL General Services**	85,535	106,618	107,010	299,163		299,163	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	55,789	88	588	56,465		56,465	6
7	Activities and Social Services	30,464	4,711	3,134	38,309		38,309	7
8	Other (specify): CNA support services	91,873			91,873		91,873	8
9	**TOTAL Health Care and Programs**	178,126	4,799	3,722	186,647		186,647	9
	C. General Administration							
10	Administrative and Clerical	116,490	4,749	17,473	138,712		138,712	10
11	Marketing Materials, Promotions and Advertising			5,696	5,696		5,696	11
12	Employee Benefits and Payroll Taxes	109,787			109,787		109,787	12
13	Insurance-Property, Liability and Malpractice			20,145	20,145		20,145	13
14	Other (specify): Legal fees, loan fees, computer consult., background cks, TB tests.			26,949	26,949		26,949	14
15	**TOTAL General Administration**	226,277	4,749	70,263	301,289		301,289	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	489,938	116,166	180,995	787,099		787,099	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			211,280	211,280		211,280	17
18	Interest			371,293	371,293		371,293	18
19	Real Estate Taxes			32,046	32,046		32,046	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			614,619	614,619		614,619	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	489,938	116,166	795,614	1,401,718		1,401,718	24

Facility Name: Autumn Ridge **Report Period Beginning: 7/1/2016 Ending: 6/30/2017**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.88	$ 21.22	1
2	Licensed Practical Nurses	0.88	12.63	2
3	Certified Nurse Assistants	9.00	9.00	3
4	Activity Director & Assistants	0.90	12.87	4
5	Social Service Workers			5
6	Head Cook	1.00	10.50	6
7	Cook Helpers/Assistants	3.48	8.80	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	0.48	8.83	10
11	Laundry			11
12	Managers	2	19.14	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	18.62	$	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

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
N/A								

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: 7/1/2016 Ending: 6/30/2017

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	$	$ 1,524,320	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Land Improvements			2007	442,824	12,110		12,110		111,824	6
7	Entrance Sign			2012	10,892	727		727		3,874	7
8	Lighting			2017	43,614	2,324		2,324		2,324	8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 5,729,993	$ 181,582		$ 181,582	$	$ 1,642,342	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	$ 255,919	18
19	Vehicles	34,018				5	34,018	19
20	TOTAL (lines 18 and 19)	$ 308,202	$ 28,567	$ 28,567	$		$ 289,937	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:** 7/1/2016 **Ending:** 6/30/2017

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	$ 4,959,608	3/1/47	6.9500	$ 351,307	1
2	USDA		X	Building Construction	/ /	1,018,324	974,274	3/1/48	1.0000	19,986	2
3	DeLage Financial		X	Lease Copier payable	/ /	9,861	8,677	12/28/20	9.5450		3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 6,279,185	$ 5,942,559			$ 371,293	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 6,279,185	$ 5,942,559			$ 371,293	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:** 7/1/2016 **Ending:** 6/30/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2017 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 299,407	$	1
2	Cash-Patient Deposits	36,945		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	254,980		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,337		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)**	$ 627,669	$	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	5,285,877		14
15	Leasehold Improvements, at Historical Cost	253,108		15
16	Equipment, at Historical Cost	317,547		16
17	Accumulated Depreciation (book methods)	(1,932,279)		17
18	Deferred Charges	15,020		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)**	$ 4,128,989	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,756,658	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 8,708	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,945		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,111		30
31	Accrued Taxes Payable	4,296		31
32	Accrued Interest Payable	28,760		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)**	$ 114,820	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	5,942,559		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)**	$ 5,942,559	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 6,057,379	$	45
46	**TOTAL EQUITY**	$ (1,300,721)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 4,756,658	$	47

***(See instructions.)**

Facility Name: Autumn Ridge **Report Period Beginning: 7/1/2016 Ending: 6/30/2017**

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	$ 1,330,420	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,330,420	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	9,660	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 9,660	11
	C. Non-Operating Revenue		
12	Contributions	5,431	12
13	Interest and Other Investment Income	60	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 5,491	14
	D. Other Revenue (specify):		
15	**Storage Building Rental**	3,320	15
16	**Medical Transportation**	1,735	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 5,055	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,350,626	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	299,163	19
20	Health Care/ Personal Care	186,647	20
21	General Administration	301,289	21
	B. Capital Expense		
22	Ownership	614,619	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)**	$ 1,401,718	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (51,092)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (51,092)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 394,172	32
33	Private Pay - Net Inpatient Revenue	867,619	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) **SNAP/LINK**	32,517	35
36	Other-(specify) **USDA Subsidy**	36,112	36
37	TOTAL (This total must agree to Line 3)	$ 1,330,420	37