

		FOR BHF USE			

LL2

Supportive Living Facility

2015

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2015)

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 Vienna 62995

Number City 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:

<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	<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input type="checkbox"/>	"Sub-S" Corp.	<input type="checkbox"/>	
		<input type="checkbox"/>	Limited Liability Co.	<input type="checkbox"/>	
		<input type="checkbox"/>	Trust	<input type="checkbox"/>	
		<input type="checkbox"/>	Other	<input type="checkbox"/>	

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

Name: Stephanie Newcomb 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 7/1/14 to 6/30/15 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) 9/30/2015 (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

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	<u>39</u>	Single Unit Apartment	<u>39</u>	<u>14,235</u>	1
2	<u>7</u>	Double Unit Apartment	<u>7</u>	<u>2,555</u>	2
3		Other			3
4	<u>46</u>	TOTALS	<u>46</u>	<u>16,790</u>	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	<u>9,470</u>	<u>2,917</u>		<u>12,387</u>	5
6	Double Unit	<u>340</u>	<u>1,018</u>		<u>1,358</u>	6
7	Other					7
8	TOTALS	<u>9,810</u>	<u>3,935</u>		<u>13,745</u>	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 81.86%

D. Indicate the number of paid bed-hold days the SLF had during this year 194 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: 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.

STATE OF ILLINOIS

Facility Name: Autumn Ridge

Report Period Beginning:

7/1/14

Ending:

Page 3

6/30/15

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	63,367	90,584	3,102	157,053		157,053	1
2	Housekeeping, Laundry and Maintenance	108,640	5,289	55,726	169,655		169,655	2
3	Heat and Other Utilities			59,324	59,324		59,324	3
4	Other (specify):Waste Management			1,600	1,600		1,600	4
5	TOTAL General Services	172,007	95,873	119,752	387,632		387,632	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	34,539	182	255	34,976		34,976	6
7	Activities and Social Services	19,354	3,273	282	22,909		22,909	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	53,893	3,455	537	57,885		57,885	9
	C. General Administration							
10	Administrative and Clerical	112,662	5,155		117,817		117,817	10
11	Marketing Materials, Promotions and Advertising			6,991	6,991		6,991	11
12	Employee Benefits and Payroll Taxes	102,677			102,677		102,677	12
13	Insurance-Property, Liability and Malpractice			20,166	20,166		20,166	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	215,339	5,155	66,191	286,685		286,685	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	441,239	104,483	186,480	732,202		732,202	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			207,407	207,407		207,407	17
18	Interest			376,355	376,355		376,355	18
19	Real Estate Taxes			45,430	45,430		45,430	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			629,192	629,192		629,192	23
24	GRAND TOTAL (Sum of lines 16 and 23)	441,239	104,483	815,672	1,361,394		1,361,394	24

Facility Name: Autumn Ridge

Report Period Beginning 7/1/14 Ending: 6/30/15

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 23.51	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6	8.63	3
4	Activity Director & Assistants	1	12.62	4
5	Social Service Workers			5
6	Head Cook	1	20.44	6
7	Cook Helpers/Assistants	4	9.35	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	16.85	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	14	\$	17

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

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).

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	
1	No payments made to owners, relatives and members of Board of Directors				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

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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	\$ 5,232,663	\$ 167,151		\$ 167,151		\$ 1,191,477	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Land Improvements			2007	442,824	12,353		12,353		87,604	6
7	Entrance Sign			2012	10,892	484		484		2,420	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	\$ 179,988		\$ 179,988		\$ 1,281,501	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	\$ 198,785	18
19	Vehicles	34,018				5	34,018	19
20	TOTAL (lines 18 and 19)	\$ 308,202	\$ 27,419	\$ 27,419			\$ 232,803	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

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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 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

☒ 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	\$ 5,049,101	3/1/47	6.9500	\$ 357,429	1
2	USDA		X	Building Construction	/ /	1,018,324	986,617	3/1/48	1.0000	18,926	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 6,269,324	\$ 6,035,718			\$ 376,355	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 6,269,324	\$ 6,035,718			\$ 376,355	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.

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/15

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 420,043	\$	1
2	Cash-Patient Deposits	35,912		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	250,411		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,346		6
7	Other Prepaid Expenses	30,031		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 742,743	\$	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)	(1,514,304)		17
18	Deferred Charges	16,483		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)	\$ 4,485,868	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,228,611	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 46,529	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,237		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,071		30
31	Accrued Taxes Payable	1,247		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)	\$ 138,825	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	6,035,719		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)	\$ 6,035,719	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 6,174,544	\$	45
46	TOTAL EQUITY	\$ (945,933)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,228,611	\$	47

*(See instructions.)

Facility Name: Autumn Ridge

Report Period Beginning: 7/1/14

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

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,189,837	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,189,837	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	4,049	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 4,049	11
	C. Non-Operating Revenue		
12	Contributions/Fund Raiser	4,432	12
13	Interest and Other Investment Income	359	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 4,791	14
	D. Other Revenue (specify):		
15	Storage Building Rental	4,590	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 4,590	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,203,267	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	387,632	19
20	Health Care/ Personal Care	57,885	20
21	General Administration	286,685	21
	B. Capital Expense		
22	Ownership	629,192	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)	\$ 1,361,394	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (158,127)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (158,127)	31