

		FOR BHF USE			

LL2

Supportive Living Facility

2018

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2018)

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 ADM 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: 1000095</p> <p>Facility Name: Autumn Ridge</p> <p>Address: 1000 Galeener Street Vienna 62995</p> <p>County: Johnson</p> <p>Telephone Number: ( 618 ) 658-2775 Fax # 618 658-4303</p> <p>Federal Employer ID Number:</p> <p>Date Current Owners were Certified: 9-8-2008</p> <p>Type of Ownership:</p> <table><tr><td><input checked="" type="checkbox"/></td><td>VOLUNTARY, NON-PROFIT</td><td><input type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input checked="" type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td></td><td>IRS Exemption Code</td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other</td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Other</td><td></td><td></td></tr></table> <p>In the event there are further questions about this report, please contact:</p> <p>Name: Nora Beth Hacker Telephone Number: ( 618 ) 683-2461</p> <p>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	<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 7/1/2017 to 6/30/2018 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><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed)</td><td>9/24/2018</td></tr><tr><td>(Type or Print Name)</td><td>Sherrie L. Crabb</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Title)</td><td>Executive Director</td></tr><tr><td>(Signed)</td><td></td></tr><tr><td>(Date)</td><td></td></tr><tr><td>(Print Name and Title)</td><td></td></tr><tr><td>(Firm Name &amp; Address)</td><td></td></tr><tr><td></td><td>(Telephone)</td><td>Fax # ( )</td></tr></table> <p>MAIL TO: BUREAU OF HEALTH FINANCIAL SERVICES IL DEPT OF HEALTHCARE AND FAMILY SERVICE 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed)	9/24/2018	(Type or Print Name)	Sherrie L. Crabb	Paid Preparer	(Title)	Executive Director	(Signed)		(Date)		(Print Name and Title)		(Firm Name & Address)			(Telephone)	Fax # ( )
<input checked="" type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL																																																															
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Facility Name Autumn Ridge

Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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	46	TOTALS	46	16,790	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>7,436</u>	<u>6,107</u>		<u>13,543</u>	5
6	Double Unit	<u>176</u>	<u>62</u>		<u>238</u>	6
7	Other					7
8	TOTALS	7,612	6,169		13,781	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 82.08%

D. Indicate the number of paid bed-hold days the SLF had during this year 99 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 principal? 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 principal? 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 principal? N/A  
If no, explain.

## STATE OF ILLINOIS

Page 3

Facility Name: Autumn Ridge

Report Period Beginning:

7/1/2017

Ending:

6/30/2018

## 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	78,008	102,367	7,169	187,544		187,544	1
2	Housekeeping, Laundry and Maintenance	19,564	2,138	44,491	66,193		66,193	2
3	Heat and Other Utilities			53,289	53,289		53,289	3
4	Other (specify): Waste Management			1,565	1,565		1,565	4
5	<b>TOTAL General Services</b>	97,572	104,505	106,514	308,591		308,591	5
	<b>B. Health Care and Programs</b>							
6	Health Care/ Personal Care	59,661	165	571	60,397		60,397	6
7	Activities and Social Services	31,939	2,602	48	34,589		34,589	7
8	Other (specify): CNA Suport Services	100,678		2,363	103,041		103,041	8
9	<b>TOTAL Health Care and Programs</b>	192,278	2,767	2,982	198,027		198,027	9
	<b>C. General Administration</b>							
10	Administrative and Clerical	127,504	4,760	19,176	151,440		151,440	10
11	Marketing Materials, Promotions and Advertising			4,445	4,445		4,445	11
12	Employee Benefits and Payroll Taxes	133,068			133,068		133,068	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			36,522	36,522		36,522	14
15	<b>TOTAL General Administration</b>	260,572	4,760	79,978	345,310		345,310	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	550,422	112,032	189,474	851,928		851,928	16
	<b>Capital Expenses</b>							
	<b>D. Ownership</b>							
17	Depreciation			199,847	199,847		199,847	17
18	Interest			367,534	367,534		367,534	18
19	Real Estate Taxes			35,465	35,465		35,465	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			602,846	602,846		602,846	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	550,422	112,032	792,320	1,454,774		1,454,774	24

Facility Name: Autumn Ridge

Report Period Beginning 7/1/2017 Ending: 6/30/2018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.88	\$ 21.76	1
2	Licensed Practical Nurses	0.70	13.77	2
3	Certified Nurse Assistants	9.00	10.16	3
4	Activity Director & Assistants	0.90	14.01	4
5	Social Service Workers			5
6	Head Cook	1.00	11.61	6
7	Cook Helpers/Assistants	3.50	9.67	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	0.48	9.83	10
11	Laundry			11
12	Managers	2.00	19.30	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	18.46	\$	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
N/A			

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

Facility Name: Autumn Ridge

Report Period Beginning: 7/1/2017

Ending: 6/30/2018

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	\$	\$ 1,690,741	1
2											2
3											3
4											4
5											5
	Improvement Typ										
6	Land Improvements			2007	442,824	12,110		12,110		123,934	6
7	Entrance Sign			2012	10,892	727		727		4,601	7
8	Lighting			2017	43,614	2,324		2,324		4,648	8
9	Entrance Sign			2018	5,548						9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 5,735,541	\$ 181,582		\$ 181,582	\$	\$ 1,823,924	17

C. Equipment Depreciation -- Including Transportatio

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipmen	\$ 274,184	\$ 18,265	\$ 18,265	\$	10	\$ 274,184	18
19	Vehicles	34,018				5	34,018	19
20	TOTAL (lines 18 and 19)	\$ 308,202	\$ 18,265	\$ 18,265	\$		\$ 308,202	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: 7/1/2017 Ending: 7/30/2018

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 amount? 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	\$ 4,909,408	3/1/47	6.9500	\$ 347,901	1
2	USDA		X	Building Construction	/ /	1,018,324	967,817	3/1/48	1.0000	19,633	2
3	DeLage Financial		X	Lease Copier Payable	/ /	9,861	6,460	12/28/20	9.5450		3
	Working Capita										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 6,279,185	\$ 5,883,685			\$ 367,534	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 6,279,185	\$ 5,883,685			\$ 367,534	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: 7/1/2017

Ending: 6/30/2018

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2018

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 402,524	\$	1
2	Cash-Patient Deposits	33,208		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	141,015		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 576,747	\$	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	5,285,877		14
15	Leasehold Improvements, at Historical Cost	253,108		15
16	Equipment, at Historical Cost	323,611		16
17	Accumulated Depreciation (book methods)	(2,132,010)		17
18	Deferred Charges	14,289		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,934,591	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,511,338	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 48,092	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,208		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,794		30
31	Accrued Taxes Payable	2,049		31
32	Accrued Interest Payable	28,794		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 (sum of lines 26 thru 36)</b>	\$ 138,937	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	5,883,685		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 (sum of lines 38 thru 43)</b>	\$ 5,883,685	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 6,022,622	\$	45
46	<b>TOTAL EQUITY</b>	\$ (1,496,053)	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 4,526,569	\$	47

\*(See instructions.)

Facility Name: Autumn Ridge

Report Period Beginning: 7/1/2017

Ending:

6/30/2018

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

		1	
	<b>I. Revenue</b>	<b>Amount</b>	
	<b>A. SLF Resident Care</b>		
1	Gross SLF Resident Revenue	\$ 1,229,271	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	\$ 1,229,271	3
	<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	9,676	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	\$ 9,676	11
	<b>C. Non-Operating Revenue</b>		
12	Contributions	2,946	12
13	Interest and Other Investment Income	414	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	\$ 3,360	14
	<b>D. Other Revenue (specify):</b>		
15	Storage Building Rental	3,140	15
16	Medical Transportation	760	16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	\$ 3,900	17
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	\$ 1,246,207	18

		2	
	<b>II. Expenses</b>	<b>Amount</b>	
	<b>A. Operating Expenses</b>		
19	General Services	308,591	19
20	Health Care/ Personal Care	198,027	20
21	General Administration	345,310	21
	<b>B. Capital Expense</b>		
22	Ownership	602,846	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>	\$ 1,454,774	28
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	\$ (208,567)	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	\$ (208,567)	31
	<b>III. Net Resident Care Revenue detailed by Payer Source</b>		
32	Medicaid - Net Inpatient Revenue	\$ 408,312	32
33	Private Pay - Net Inpatient Revenue	754,389	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <a href="#">SNAP/LINK</a>	30,899	35
36	Other-(specify) <a href="#">USDA Subsidy</a>	35,671	36
37	<b>TOTAL (This total must agree to Line 3)</b>	\$ 1,229,271	37