

		FOR BHF USE			

LL2

Supportive Living Facility

2019

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2019)

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 StreetVienna62995

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

x

Charitable Corp.

Trust

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

IRS Exemption Code

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

Name: Nora Bullock, CFO

Telephone Number: (618 683-2461

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 7/1/18 to 6/30/19 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)

(Type or Print Name) Sherrie L. Crabb

(Title) Chief Executive Officer

Paid Preparer

(Signed)

(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: 7/1/18 Ending: 6/30/19

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	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	7,029	5,712		12,741	5
6	Double Unit	703	454		1,157	6
7	Other					7
8	TOTALS	7,732	6,166		13,898	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 82.78%

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

119 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

ACCRAUAL ☒ 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. N/A

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. N/A

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. N/A

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7/1/18

Ending:

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6/30/19

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	90,413	95,522	4,353	190,288		190,288	1
2	Housekeeping, Laundry and Maintenance	14,680	3,327	41,479	59,486		59,486	2
3	Heat and Other Utilities			50,029	50,029		50,029	3
4	Other (specify): Waste Management			1,625	1,625		1,625	4
5	TOTAL General Services	105,093	98,849	97,486	301,428		301,428	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	63,161	127	64	63,352		63,352	6
7	Activities and Social Services	24,637	3,533	24	28,194		28,194	7
8	Other (specify): Certified Nurses Aid Support Services	108,892			108,892		108,892	8
9	TOTAL Health Care and Programs	196,690	3,660	88	200,438		200,438	9
	C. General Administration							
10	Administrative and Clerical	136,821	3,893	25,906	166,620		166,620	10
11	Marketing Materials, Promotions and Advertising			3,544	3,544		3,544	11
12	Employee Benefits and Payroll Taxes	141,139			141,139		141,139	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			31,460	31,460		31,460	14
15	TOTAL General Administration	277,960	3,893	80,745	362,598		362,598	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	579,743	106,402	178,319	864,464		864,464	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			184,110	184,110		184,110	17
18	Interest			363,776	363,776		363,776	18
19	Real Estate Taxes			53,220	53,220		53,220	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			601,106	601,106		601,106	23
24	GRAND TOTAL (Sum of lines 16 and 23)	579,743	106,402	779,425	1,465,570		1,465,570	24

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 22.83	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	10.86	10.47	3
4	Activity Director & Assistants	0.50	14.55	4
5	Social Service Workers			5
6	Head Cook	1	12.18	6
7	Cook Helpers/Assistants	3.50	10.18	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	0.48	10.33	10
11	Laundry			11
12	Managers	2	19.98	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	19.34	\$	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			

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

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).

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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	\$	1,857,162	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Land Improvements			2007	442,824	12,110		12,110		136,047	6
7	Entrance Sign			2012	10,892	726		726		5,325	7
8	Lighting			2017	43,614	2,324		2,324		6,972	8
9	Entrance Sign			2018	5,548	176		176		191	9
10	CCTV Assembly (additional security cameras)			2019	10,000	1,000		1,000		1,000	10
11	Carpet			2018	12,044	319		319		319	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 5,757,585	\$ 183,076		\$ 183,076	\$	2,007,016	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	\$ 283,784	\$ 1,034	\$ 1,034	\$	10	\$ 278,548	18
19	Vehicles	34,018				5	34,018	19
20	TOTAL (lines 18 and 19)	\$ 317,802	\$ 1,034	\$ 1,034	\$		\$ 312,566	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	\$ 4,855,558	3/1/47	6.9500	\$ 344,250	1
2	USDA		X	Building Construction	/ /	1,018,324	960,987	3/1/48	1.0000	19,261	2
3	DeLage Financial		X	Lease Copier Payable	/ /	9,861	1,283	12/28/20	9.5450	265	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 6,279,185	\$ 5,817,828			\$ 363,776	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 6,279,185	\$ 5,817,828			\$ 363,776	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 6/30/19

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 344,393	\$	1
2	Cash-Patient Deposits	36,735		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	142,169		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	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 523,297	\$	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	275,142		15
16	Equipment, at Historical Cost	323,621		16
17	Accumulated Depreciation (book methods)	(2,319,582)		17
18	Deferred Charges	13,558		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)	\$ 3,768,332	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,291,629	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 28,868	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,735		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,794		30
31	Accrued Taxes Payable	1,450		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)	\$ 122,588	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	5,817,828		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)	\$ 5,817,828	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,940,416	\$	45
46	TOTAL EQUITY	\$ (1,648,787)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,291,629	\$	47

*(See instructions.)

Facility Name: Autumn Ridge

Report Period Beginning: 7/1/18

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

		1	
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,268,042	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,268,042	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	7,677	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 7,677	11
	C. Non-Operating Revenue		
12	Contributions	8,810	12
13	Interest and Other Investment Income	6,392	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 15,202	14
	D. Other Revenue (specify):		
15	Storage Building Rental	3,360	15
16	Medical Transportation	1,555	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 4,915	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,295,836	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	301,428	19
20	Health Care/ Personal Care	200,438	20
21	General Administration	362,598	21
	B. Capital Expense		
22	Ownership	601,106	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)	\$ 1,465,570	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (169,734)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (169,734)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 403,430	32
33	Private Pay - Net Inpatient Revenue	792,280	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) SNAP/LINK	37,031	35
36	Other-(specify) USDA Subsidy	35,301	36
37	TOTAL (This total must agree to Line 3)	\$ 1,268,042	37