

		FOR BHF USE			

LL2

Supportive Living Facility

2020

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2020)

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

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

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

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

Name:

Telephone Number: ()

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 7/1/19 to 6/30/20 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: 7/1/19 Ending: 6/30/20

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	7,987	6,291		14,278	5
6	Double Unit	732	732		1,464	6
7	Other					7
8	TOTALS	8,719	7,023		15,742	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.76%

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

100 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. 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

STATE OF ILLINOIS

Facility Name: Autumn Ridge

Report Period Beginning:

7/1/19

Ending:

Page 3
6/30/20

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	135,683	113,901	6,069	255,653		255,653	1
2	Housekeeping, Laundry and Maintenance	30,800	3,978	40,034	74,812		74,812	2
3	Heat and Other Utilities			53,602	53,602		53,602	3
4	Other (specify): Waste Management			1,733	1,733		1,733	4
5	TOTAL General Services	166,483	117,879	101,438	385,800		385,800	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	53,079	1,086	265	54,430		54,430	6
7	Activities and Social Services	17,986	2,891	2,370	23,247		23,247	7
8	Other (specify): Certified Nurses Aid Support Services	144,967	220	15,181	160,368		160,368	8
9	TOTAL Health Care and Programs	216,032	4,197	17,816	238,045		238,045	9
	C. General Administration							
10	Administrative and Clerical	113,035	4,478	1,267	118,780		118,780	10
11	Marketing Materials, Promotions and Advertising			3,911	3,911		3,911	11
12	Employee Benefits and Payroll Taxes	132,475			132,475		132,475	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			24,001	24,001		24,001	14
15	TOTAL General Administration	245,510	4,478	49,014	299,002		299,002	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	628,025	126,554	168,268	922,847		922,847	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			185,173	185,173		185,173	17
18	Interest			357,025	357,025		357,025	18
19	Real Estate Taxes			53,415	53,415		53,415	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			595,613	595,613		595,613	23
24	GRAND TOTAL (Sum of lines 16 and 23)	628,025	126,554	763,881	1,518,460		1,518,460	24

Facility Name: Autumn Ridge

Report Period Beginning 7/1/19 Ending: 6/30/20

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.00	\$ 23.83	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.50	11.38	3
4	Activity Director & Assistants	0.50	15.55	4
5	Social Service Workers			5
6	Head Cook	1.00	14.09	6
7	Cook Helpers/Assistants	3.50	11.29	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	0.50	10.33	10
11	Laundry			11
12	Managers	2.50	20.74	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	16.50	\$	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).

Facility Name: Autumn Ridge

Report Period Beginning:

7/1/19

Ending:

6/30/20

VIII. OWNERSHIP COSTS

A. Purchase price of land 189,716 Year land was acquired 2008

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	\$ 167,806		\$ 167,806	\$	2,023,583	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Land Improvements			2007	442,824	12,111		12,111		148,158	6
7	Entrance Sign			2012	10,892	726		726		6,051	7
8	Lighting			2017	43,614	2,972		2,972		9,296	8
9	Entrance Sign			2018	5,548	176		176		367	9
10	CCTV Assembly (additional security cameras)			2019	10,000	1,000		1,000		3,000	10
11	Carpet			2018	12,044	382		382		701	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 5,757,585	\$ 185,173		\$ 185,173	\$	2,191,156	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	\$ 279,582	18
19	Vehicles	34,018				5	34,018	19
20	TOTAL (lines 18 and 19)	\$ 317,802	\$ 1,034	\$ 1,034	\$		\$ 313,600	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: 7/1/19

Ending: 6/30/20

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1	Peoples National Bank		x	Building Construction	/ /	\$ 5,251,000	\$	3/1/47	6.9500	\$ 4,798,731	1
2	USDA		x	Building Construction	/ /	1,018,324		3/1/48	1.0000	954,996	2
3	DeLage Financial		x	Lease Copier Payable	/ /	9,861		12/28/20	9.5450	1,283	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 6,279,185	\$			\$ 5,755,010	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 6,279,185	\$			\$ 5,755,010	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.

STATE OF ILLINOIS

Facility Name: Autumn Ridge

Report Period Beginning: 7/1/19

Ending:

Page 7

6/30/20

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/20

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 719,842	\$	1
2	Cash-Patient Deposits	34,685		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	96,601		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)	\$ 851,128	\$	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)	(2,504,755)		17
18	Deferred Charges	12,827		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)	\$ 3,582,428	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,433,556	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 11,439	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,685		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,520		30
31	Accrued Taxes Payable	2,975		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)	\$ 120,360	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	5,755,010		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)	\$ 5,755,010	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,875,370	\$	45
46	TOTAL EQUITY	\$ (1,441,814)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,433,556	\$	47

*(See instructions.)

Facility Name: Autumn Ridge

Report Period Beginning: 7/1/19

Ending:

6/30/20

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	\$ 1,520,149	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,520,149	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	3,357	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 3,357	11
	C. Non-Operating Revenue		
12	Contributions	373	12
13	Interest and Other Investment Income	2,597	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,970	14
	D. Other Revenue (specify):		
15	Storage Building Rental	4,610	15
16	Paycheck Protection Funds/IL COVID Response Fun	194,347	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 198,957	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,725,433	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	385,800	19
20	Health Care/ Personal Care	238,045	20
21	General Administration	299,002	21
	B. Capital Expense		
22	Ownership	595,613	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)	\$ 1,518,460	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 206,973	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 206,973	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 582,128	32
33	Private Pay - Net Inpatient Revenue	860,404	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) SNAP/LINK	42,712	35
36	Other-(specify) USDA Subsidy	34,905	36
37	TOTAL (This total must agree to Line 3)	\$ 1,520,149	37