FOR BHF USE

LL2

Supportive Living Facility

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2013)

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: 1000039

Facility Name: Mary Bryant Home F/T Blind

Address: 2960 Stanton Ave (Number) Springfield (City) 62703 (Zip Code)

County: Sangamon

Telephone Number: (217) 529-1611 **Fax #** 217 529-6975

Federal Employer ID Number:

Date Current Owners were Certified: 7/08/2004

Type of Ownership:

	VOLUNTARY, NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Joe Brockamp **Telephone Number:** (217 793-3363
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 4/01/12 to 3/31/13 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) Jerry Curry
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Joe Brockamp, Treasurer
(Firm Name & Address) Sikich LLP, 3201 W White Oaks Dr, Springfield, IL 62704
(Telephone) 217 793-3363 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 Mary Bryant Home F/T Blind Report Period Beginning: 4/01/12 Ending: 3/31/13

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		Single Unit Apartment			1
2		Double Unit Apartment			2
3		Other			3
4		TOTALS		15,330	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					5
6	Double Unit					6
7	Other					7
8	TOTALS	13,436	730		14,166	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.41%

D. Indicate the number of paid bed-hold days the SLF had during this year _____ **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** _____ **(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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

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* [X] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 3/31 Fiscal Year: 3/31
* 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?** _____
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?** _____
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?** _____
If no, explain. _____

Facility Name: Mary Bryant Home F/T Blind **Report Period Beginning: 4/01/12 Ending: 3/31/13**

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	72,294	67,491	1,184	140,969		140,969	1
2	Housekeeping, Laundry and Maintenance	93,488	15,733	47,357	156,578		156,578	2
3	Heat and Other Utilities			126,567	126,567		126,567	3
4	Other (specify):							4
5	**TOTAL General Services**	165,782	83,224	175,108	424,114		424,114	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	197,037	4,637		201,674		201,674	6
7	Activities and Social Services	43,532	38,890	2,418	84,840		84,840	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	240,569	43,527	2,418	286,514		286,514	9
	C. General Administration							
10	Administrative and Clerical	139,724		40,175	179,899		179,899	10
11	Marketing Materials, Promotions and Advertising			7,739	7,739		7,739	11
12	Employee Benefits and Payroll Taxes			106,714	106,714		106,714	12
13	Insurance-Property, Liability and Malpractice			47,279	47,279		47,279	13
14	Other (specify):							14
15	**TOTAL General Administration**	139,724		201,907	341,631		341,631	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	546,075	126,751	379,433	1,052,259		1,052,259	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			74,388	74,388		74,388	17
18	Interest			12,244	12,244		12,244	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			86,632	86,632		86,632	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	546,075	126,751	466,065	1,138,891		1,138,891	24

Facility Name: Mary Bryant Home F/T Blind Report Period Beginning 4/01/12 Ending: 3/31/13

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 21.00	1
2	Licensed Practical Nurses	1	14.00	2
3	Certified Nurse Assistants	5	11.00	3
4	Activity Director & Assistants	1	13.00	4
5	Social Service Workers	1	12.00	5
6	Head Cook	1	13.00	6
7	Cook Helpers/Assistants	2	11.00	7
8	Dishwashers			8
9	Maintenance Workers	2	15.00	9
10	Housekeepers	1	11.00	10
11	Laundry	1	10.00	11
12	Managers	1	31.00	12
13	Other Administrative	1	18.00	13
14	Clerical	2	17.00	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	20	$	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	
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

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 [X]
Name of related entity: _____ 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 [X]
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: Mary Bryant Home F/T Blind Report Period Beginning: 4/01/12 Ending: 3/31/13

VIII. OWNERSHIP COSTS

A. Purchase price of land 147,030 Year land was acquired 1982

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				1982-1983	$ 2,216,214	$ 44,324		$	$	$ 1,311,257	1
2				2004-2006	539,487	13,487				106,328	2
3											3
4											4
5											5
	Improvement Type										
6	Pavillion			8/6/1991	28,791	720				15,597	6
7	Sidewalks			6/30/1992	3,927	51				3,927	7
8	Breakroom Remodeling			10/21/1992	898	23				456	8
9	Outdoor Sign & Lights			12/8/1993	1,612					1,612	9
10	A/C Coil			5/23/2001	11,300					11,300	10
11	Roof A/C			4/1/2002	6,000					6,000	11
12	A/C Unit			10/26/2007	20,059	1,791				17,374	12
13	Dumpster Area Gate			11/11/2008	1,129	56				249	13
14	New Roof			10/25/2010	58,719	2,349				5,676	14
15	Climate Control Upgrade			3/13/2012	35,000	875				948	15
16	AC Chillers			2/28/2013	58,000	121				121	16
17	TOTAL (lines 1 thru 16)				$ 2,981,136	$ 63,797		$	$	$ 1,480,845	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	$ 252,186	$ 4,660	$			$ 242,169	18
19	Vehicles	23,565	5,931				18,546	19
20	TOTAL (lines 18 and 19)	$ 275,751	$ 10,591	$	$		$ 260,715	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: Mary Bryant Home F/T Blind Report Period Beginning: 4/01/12 Ending: 3/31/13

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

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 [ ] 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

	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	Chase Bank		X	Mortgage	/ /	$ 1,500,000	$ 61,686	/ /		$ 2,506	1
2	IL Facilities Fund		X	Mortgage	/ /	387,118	204,448	/ /		9,738	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 1,887,118	$ 266,134			$ 12,244	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 1,887,118	$ 266,134			$ 12,244	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: Mary Bryant Home F/T Blind **Report Period Beginning:** 4/01/12 **Ending:** 3/31/13

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 3/31/13 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 120,783	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at cost)	14,622		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)**	$ 135,405	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	179,552		12
13	Land	147,030		13
14	Buildings, at Historical Cost	2,981,136		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	275,751		16
17	Accumulated Depreciation (book methods)	(1,740,096)		17
18	Deferred Charges			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)**	$ 1,843,373	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,978,778	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 257	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			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)**	$ 257	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	266,134		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)**	$ 266,134	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 266,391	$	45
46	**TOTAL EQUITY**	$ 1,712,387	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 1,978,778	$	47

***(See instructions.)**

Facility Name: Mary Bryant Home F/T Blind **Report Period Beginning: 4/01/12 Ending: 3/31/13**

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

	Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,146,852	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,146,852	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
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$	11
	C. Non-Operating Revenue		
12	Contributions	91,523	12
13	Interest and Other Investment Income	6,690	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 98,213	14
	D. Other Revenue (specify):		
15	**Low Vision Store**	54,143	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 54,143	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,299,208	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	424,114	19
20	Health Care/ Personal Care	286,514	20
21	General Administration	341,631	21
	B. Capital Expense		
22	Ownership	86,632	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)**	$ 1,138,891	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 160,317	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 160,317	31