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: 1000074

Facility Name: Joshua Arms of LSSI

Address: 1315 Rowell Avenue (Number) Joliet (City) 60433 (Zip Code)

County: Will

Telephone Number: (815) 722-6401 **Fax #** (815) 727-6477

Federal Employer ID Number:

Date Current Owners were Certified: 7/1/2014

Type of Ownership:

[X] 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: Steve Lavenda **Telephone Number:** (847) 236 - 282 - 6300
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 7/1/2014 to 6/30/2015 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)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Steven N. Lavenda, C.P.A.
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282 - 6300 Fax (847) 282 -6301

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 Joshua Arms of LSSI Report Period Beginning: 7/1/2014 Ending: 6/30/2015

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units N/A

	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	56	Single Unit Apartment	56	20,440	1
2		Double Unit Apartment			2
3		Other			3
4	56	TOTALS	56	20,440	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	12,082	2,153		14,235	5
6	Double Unit					6
7	Other					7
8	TOTALS	12,082	2,153		14,235	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 69.64%

D. Indicate the number of paid bed-hold days the SLF had during this year 118 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 20 **(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 [X] NO [ ]

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

H. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 6/30/2015 Fiscal Year: 6/30/2015
* 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: Joshua Arms of LSSI **Report Period Beginning: 7/1/2014 Ending: 6/30/2015**

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	141,992	621	144,018	286,631	(58,057)	228,574	1
2	Housekeeping, Laundry and Maintenance	45,880	37,080	104,626	187,586		187,586	2
3	Heat and Other Utilities							3
4	Other (specify):							4
5	**TOTAL General Services**	187,872	37,701	248,644	474,217	(58,057)	416,160	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	268,070		46,018	314,088		314,088	6
7	Activities and Social Services	33,212		12	33,224		33,224	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	301,282		46,030	347,312		347,312	9
	C. General Administration							
10	Administrative and Clerical	87,785	3,753	22,791	114,329		114,329	10
11	Marketing Materials, Promotions and Advertising	35,404		1,437	36,841		36,841	11
12	Employee Benefits and Payroll Taxes			280,710	280,710		280,710	12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify):							14
15	**TOTAL General Administration**	123,189	3,753	304,938	431,880		431,880	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	612,343	41,454	599,612	1,253,409	(58,057)	1,195,352	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					337,643	337,643	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			1,105	1,105		1,105	21
22	Non-Reimbursable Section	404,732	31,383	1,410,607	1,846,722	(1,846,722)		22
23	**TOTAL Ownership**	404,732	31,383	1,411,712	1,847,827	(1,509,079)	338,748	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,017,075	72,837	2,011,324	3,101,236	(1,567,136)	1,534,100	24

STATE OF ILLINOIS **Page 3A**

Joshua Arms of LSSI

Report Period Beginning: **7/1/2014**
Ending: **6/30/2015**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Straight Line Depreciation	$ 337,643	17	1
2	Guest Trays/Employee Meals	(58,057)	01	2
3	Non-Reimbursable Section	(1,846,722)	22	3
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100				100

101	**Total**	(1,567,136)		**101**

Facility Name: Joshua Arms of LSSI Report Period Beginning 7/1/2014 Ending: 6/30/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		$	1
2	Licensed Practical Nurses	1.44	29.27	2
3	Certified Nurse Assistants	7.15	12.13	3
4	Activity Director & Assistants	0.80	19.95	4
5	Social Service Workers			5
6	Head Cook	2.67	13.38	6
7	Cook Helpers/Assistants	2.90	11.20	7
8	Dishwashers			8
9	Maintenance Workers	0.09	21.38	9
10	Housekeepers	1.70	11.86	10
11	Laundry			11
12	Managers	0.90	21.16	12
13	Other Administrative	0.86	18.40	13
14	Clerical	0.32	22.68	14
15	Marketing	0.81	20.89	15
16	Non-Reimbursable Section	9.01	21.59	16
17	**Total (lines 1 thru 16)**	28.66	$ 17.06	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	N/A			$	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			
Name 1		City 2	

OTHER RELATED BUSINESS ENTITIES					
Name 3		City 4		Type of Business 5	
Lutheran Social Services of IL		Des Plaines		Non-Profit	

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 [X] 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: Joshua Arms of LSSI Report Period Beginning: 7/1/2014 Ending: 6/30/2015

VIII. OWNERSHIP COSTS

A. Purchase price of land 25,714 Year land was acquired 1978

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	56		1978	1978	$ 1,470,916	$	40	$ 36,773	$ 36,773	$ 1,359,493	1
2			2007	2007	6,220,763		25	248,831	248,831	1,980,064	2
3											3
4											4
5											5
	Improvement Type										
6	Total From Supplemental Page 5's				220,518			17,228	17,228	71,578	6
7	Various			1983	12,507		20				7
8	Various			1984	21,519		20				8
9	Various			1985	2,460		20				9
10	Various			1988	2,070		20			2,070	10
11	Various			1989	4,675		20			4,675	11
12	Various			1991	7,188		20			7,188	12
13	Various			1992	65,765		20			65,765	13
14	Various			1995	125,236		20			125,236	14
15	Various			1997	2,099		20			2,099	15
16	See Page 5 continued for addition assets			1998	2,485		20				16
17	TOTAL (lines 1 thru 16)				$ 8,158,201	$		$ 302,832	$ 302,832	$ 3,618,168	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	$ 243,679	$	$ 34,811	34,811	7	$ 221,999	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	$ 243,679	$	$ 34,811	34,811		$ 221,999	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	Movable Equipment	$ 786,839	$ $ -	$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	$ 786,839	$	$	24

STATE OF ILLINOIS

Facility Name & ID Number Joshua Arms of LSSI Report Period Beginning: 7/1/2014 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
1								
2	Various	1999	24,613		20	82	82	
3	Various	2000	1,301		20			
4	Various	2001	1,739		20			
5	Various	2002	808		20			
6	Various	2007	1,005		20			
7	Various	2008	2,518		20	188	188	
8	Various	2009	3,574		20	521	521	
9	Various	2010	4,313		20	173	173	
10	Various	2011	141,949		20	14,194	14,194	
11	Hollow Metal Doors, Frames & Hardware	2012	2,714		20	271	271	
12	CLA Valve & Associated Components	2014	2,715		20	136	136	
13	Booster Pumps & Associated Components	2014	13,529		20	676	676	
14	15 PTAC Units	2014	19,740		20	987	987	
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33								
34	TOTAL (lines 1 thru 33)		$ 220,518	$		$ 17,228	$ 17,228	$

**Improvement type must be detailed in order for the cost report to be considered complete.

9 ccumulated epreciation	
	1
1,323	2
1,301	3
1,739	4
808	5
1,005	6
2,191	7
2,425	8
798	9
57,274	10
915	11
136	12
676	13
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STATE OF ILLINOIS

Facility Name & ID Number Joshua Arms of LSSI Report Period Beginning: 7/1/2014 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
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34	TOTAL (lines 1 thru 33)		$	$		$	$	$

**Improvement type must be detailed in order for the cost report to be considered complete.

9 ccumulated epreciation	
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STATE OF ILLINOIS

Facility Name & ID Number Joshua Arms of LSSI Report Period Beginning: 7/1/2014 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
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34	TOTAL (lines 1 thru 33)		$	$		$	$	$

**Improvement type must be detailed in order for the cost report to be considered complete.

9 ccumulated epreciation	
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Facility Name: Joshua Arms of LSSI **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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 ☐ 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 $ 1,105

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** 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	Assisted Living Conversion	X		Conversion of 56 unites to assisted living	/ /	$ 6,339,159	$ 4,323,619	7/1/39		$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 6,339,159	$ 4,323,619			$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 6,339,159	$ 4,323,619			$	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: Joshua Arms of LSSI **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2015 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 95,159	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	64,539		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)**	$ 159,698	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,800		13
14	Buildings, at Historical Cost	12,616,049		14
15	Leasehold Improvements, at Historical Cost	1,871,875		15
16	Equipment, at Historical Cost	1,000,186		16
17	Accumulated Depreciation (book methods)	(10,160,700)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	418,192		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,857,402	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,017,100	$	25

		1 Operating	2 After Consolidation*
	C. Current Liabilities		
26	Accounts Payable	$ 838,966	$
27	Officer's Accounts Payable		
28	Accounts Payable-Patient Deposits		
29	Short-Term Notes Payable	443,492	
30	Accrued Salaries Payable		
31	Accrued Taxes Payable		
32	Accrued Interest Payable		
33	Deferred Compensation		
34	Federal and State Income Taxes		
	Other Current Liabilities(specify):		
35	Accrued Sales Taxes	1,334	
36	Accrued Audit Fees	10,233	
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 1,294,025	$
	D. Long-Term Liabilities		
38	Long-Term Notes Payable	1,028,977	
39	Mortgage Payable	1,646,807	
40	Bonds Payable		
41	Deferred Compensation		
	Other Long-Term Liabilities(specify):		
42	Other Long Term Care Notes Payable	2,724,791	
43	Assiste living Conversion Agreement	4,323,619	
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 9,724,194	$
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 11,018,219	$
46	**TOTAL EQUITY**	$ (5,001,119)	$
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 6,017,100	$

***(See instructions.)**

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Facility Name: Joshua Arms of LSSI **Report Period Beginning: 7/1/2014 Ending: 6/30/2015**

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	$ 1,167,309	1
2	Discounts and Allowances	(109,484)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,057,825	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	58,057	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 58,057	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$	14
	D. Other Revenue (specify):		
15	**Non-Reimbursable Section**	1,907,665	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 1,907,665	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 3,023,547	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	474,217	19
20	Health Care/ Personal Care	347,312	20
21	General Administration	431,880	21
	B. Capital Expense		
22	Ownership	1,847,827	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)**	$ 3,101,236	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (77,689)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (77,689)	31