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: 1000039

Facility Name: Mary Bryant Home F-T Blind

Address: 2960 Stanton Avenue (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: 7/8/2004

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: Angela Leach **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 04/01/2014 to 03/31/2015 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) Jerry Curry
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Angela Leach, Partner
(Firm Name & Address) Sikich LLP, 3201 W White Oaks Dr, #102, Springfield, IL 62704
(Telephone) 217) 793-3363 Fax 217-793-3016

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: 04/01/2014 Ending: 03/31/2015

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	12,575	882		13,457	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 87.78%

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: 04/01/2014 Ending: 03/31/2015**

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	78,662	62,847	1,280	142,789		142,789	1
2	Housekeeping, Laundry and Maintenance	82,379	20,709	45,630	148,718		148,718	2
3	Heat and Other Utilities			112,940	112,940		112,940	3
4	Other (specify):							4
5	**TOTAL General Services**	161,041	83,556	159,850	404,447		404,447	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	206,992	3,603		210,595		210,595	6
7	Activities and Social Services	43,364	14,940	5,188	63,492		63,492	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	250,356	18,543	5,188	274,087		274,087	9
	C. General Administration							
10	Administrative and Clerical	154,037		40,741	194,778		194,778	10
11	Marketing Materials, Promotions and Advertising			51,556	51,556		51,556	11
12	Employee Benefits and Payroll Taxes			128,835	128,835		128,835	12
13	Insurance-Property, Liability and Malpractice			58,229	58,229		58,229	13
14	Other (specify):							14
15	**TOTAL General Administration**	154,037		279,361	433,398		433,398	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	565,434	102,099	444,399	1,111,932		1,111,932	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			84,761	84,761		84,761	17
18	Interest			10,023	10,023		10,023	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			94,784	94,784		94,784	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	565,434	102,099	539,183	1,206,716		1,206,716	24

Facility Name: Mary Bryant Home F-T Blind **Report Period Beginning: 04/01/2014 Ending: 03/31/2015**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 22.00	1
2	Licensed Practical Nurses	1	15.00	2
3	Certified Nurse Assistants	5	12.00	3
4	Activity Director & Assistants	1	16.00	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	16.00	9
10	Housekeepers	1	11.00	10
11	Laundry	1	10.00	11
12	Managers	1	34.00	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: 04/01/2014 Ending: 03/31/2015

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		$	$	$ 1,399,906	1
2				2004-2006	539,487	13,488				133,303	2
3											3
4											4
5											5
	Improvement Type										
6	Pavilion, Sign, Lights, Sidewalk, etc.			1991-1994	35,228	743				23,076	6
7	Roof A/C & Coil			2001-2002	17,300					17,300	7
8	A/C Unit			10/26/2007	20,059	895				20,059	8
9	Dumpster Area Gate			11/11/2008	1,129	56				362	9
10	New Roof			10/25/2010	58,719	2,349				10,374	10
11	Climate Control Upgrade			3/13/2012	35,000	875				2,698	11
12	A/C Chillers			2/28/2013	58,000	1,450				3,021	12
13	Boiler / Chiller			10/15/2013	144,176	9,612				13,283	13
14	Fire / Electrical Upgrade			3/21/2014	8,845	780				934	14
15	Heating / Cooling Upgrade			3/31/2015	361,931						15
16	Educ. Ctr. Wing Costs			10/31/2014	151,370	1,577				1,577	16
17	TOTAL (lines 1 thru 16)				$ 3,647,458	$ 76,149		$	$	$ 1,625,893	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	$ 257,399	$ 4,371	$			$ 248,314	18
19	Vehicles	13,045	4,241				10,925	19
20	TOTAL (lines 18 and 19)	$ 270,444	$ 8,612	$	$		$ 259,239	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:** 04/01/2014 **Ending:** 3/31/2015

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 [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

	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	IL Facilities Fund		X	Mortgage	/ /	$ 387,118	$ 147,124	/ /		$ 8,493	1
2	IL Facilities Fund		X	Mortgage	/ /	418,445	418,445	/ /		1,530	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 805,563	$ 565,569			$ 10,023	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 805,563	$ 565,569			$ 10,023	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:** 04/01/2014 **Ending:** 03/31/2015

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/2015 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 324,592	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced cost)	10,108		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)**	$ 334,700	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	237,187		12
13	Land	147,030		13
14	Buildings, at Historical Cost	3,647,458		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	270,444		16
17	Accumulated Depreciation (book methods)	(1,886,155)		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)**	$ 2,415,964	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,750,664	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 411	$	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)**	$ 411	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	565,569		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)**	$ 565,569	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 565,980	$	45
46	**TOTAL EQUITY**	$ 2,184,684	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 2,750,664	$	47

***(See instructions.)**

Facility Name: Mary Bryant Home F-T Blind **Report Period Beginning: 04/01/2014 Ending: 03/31/2015**

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	$ 1,013,937	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,013,937	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	248,351	12
13	Interest and Other Investment Income	3,195	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 251,546	14
	D. Other Revenue (specify):		
15	**Low Vision Store Receipts**	23,846	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 23,846	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,289,329	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	404,447	19
20	Health Care/ Personal Care	274,087	20
21	General Administration	433,398	21
	B. Capital Expense		
22	Ownership	94,784	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)**	$ 1,206,716	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 82,613	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 82,613	31