FOR BHF USE

LL2

Supportive Living Facility

2016

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)

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) 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 7/1/2015 to 6/30/2016 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)
(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: 7/1/2015 Ending: 6/30/2016

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	20,496	1
2		Double Unit Apartment			2
3		Other			3
4	56	TOTALS	56	20,496	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	11,346	3,003		14,349	5
6	Double Unit					6
7	Other					7
8	TOTALS	11,346	3,003		14,349	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 70.01%

D. Indicate the number of paid bed-hold days the SLF had during this year 120 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 22 **(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: 6/30/2016 Fiscal Year: 6/30/2016
* 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. 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 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: 7/1/2015 Ending: 6/30/2016**

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	152,909		141,799	294,708	(52,691)	242,017	1
2	Housekeeping, Laundry and Maintenance	47,967	35,577	122,945	206,489		206,489	2
3	Heat and Other Utilities							3
4	Other (specify):							4
5	**TOTAL General Services**	200,876	35,577	264,744	501,197	(52,691)	448,506	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	208,907		134,966	343,873		343,873	6
7	Activities and Social Services	34,983		11,283	46,266		46,266	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	243,890		146,249	390,139		390,139	9
	C. General Administration							
10	Administrative and Clerical	62,051	3,851	20,951	86,853		86,853	10
11	Marketing Materials, Promotions and Advertising	36,699		1,907	38,606		38,606	11
12	Employee Benefits and Payroll Taxes			311,793	311,793		311,793	12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify):							14
15	**TOTAL General Administration**	98,750	3,851	334,651	437,252		437,252	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	543,516	39,428	745,644	1,328,588	(52,691)	1,275,897	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					326,662	326,662	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			846	846		846	21
22	Other (specify):	407,929	50,102	1,596,286	2,054,317	(2,054,317)		22
23	**TOTAL Ownership**	407,929	50,102	1,597,132	2,055,163	(1,727,655)	327,508	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	951,445	89,530	2,342,776	3,383,751	(1,780,345)	1,603,406	24

Joshua Arms of LSSI

Report Period Beginning: 7/1/2015
Ending: 6/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Straight Line Depreciation	$ 326,662	17	1
2	Guest Trays/Employee Meals	(52,691)	01	2
3	Non-Reimbursable Section	(2,054,317)	22	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
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93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	**Total**	(1,780,345)		101

Facility Name: Joshua Arms of LSSI **Report Period Beginning: 7/1/2015 Ending: 6/30/2016**

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	1.18	27.59	2
3	Certified Nurse Assistants	5.14	13.23	3
4	Activity Director & Assistants	0.75	22.43	4
5	Social Service Workers			5
6	Head Cook	3.15	13.89	6
7	Cook Helpers/Assistants	2.44	12.21	7
8	Dishwashers			8
9	Maintenance Workers	0.10	24.49	9
10	Housekeepers	1.69	12.25	10
11	Laundry			11
12	Managers	0.37	24.22	12
13	Other Administrative	0.84	20.78	13
14	Clerical	0.23	14.96	14
15	Marketing	0.82	21.55	15
16	Other	8.72	22.50	16
17	Total (lines 1 thru 16)	25.42	$ 18.00	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: 7/1/2015 Ending: 6/30/2016

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	$ 1,396,266	1
2			2007	2007	6,220,763		25	248,831	248,831	2,228,895	2
3											3
4											4
5											5
	Improvement Type										
6	Total From Supplemental Page 5's				263,534			19,379	19,379	90,957	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)				$ 8,201,217	$		$ 304,982	$ 304,982	$ 3,923,150	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	$	$ 21,680	21,680	7	$ 243,679	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	$ 243,679	$	$ 21,680	21,680		$ 243,679	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

Facility Name & ID Number Joshua Arms of LSSI Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	9 Accumulated Depreciation	
1									1
2	Various	1999	24,613		20	82	82	1,405	2
3	Various	2000	1,301		20			1,301	3
4	Various	2001	1,739		20			1,739	4
5	Various	2002	808		20			808	5
6	Various	2007	1,005		20			1,005	6
7	Various	2008	2,518		20	188	188	2,379	7
8	Various	2009	3,574		20	521	521	2,946	8
9	Various	2010	4,313		20	173	173	971	9
10	Various	2011	141,949		20	14,194	14,194	71,468	10
11	Hollow Metal Doors, Frames & Hardware	2012	2,714		20	271	271	1,186	11
12	CLA Valve & Associated Components	2014	2,715		20	136	136	272	12
13	Booster Pumps & Associated Components	2014	13,529		20	676	676	1,352	13
14	15 PTAC Units	2014	19,740		20	987	987	1,974	14
15	15 PTAC Units Replacement	2015	20,310		20	1,016	1,016	1,016	15
16	Windows Glass	2015	11,430		20	572	572	572	16
17	Removal & Replacement of Hallway Carpet	2016	11,276		20	564	564	564	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 263,534	$		$ 19,379	$ 19,379	$ 90,957	34

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

Facility Name & ID Number Joshua Arms of LSSI Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	9 Accumulated Depreciation	
1									1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Joshua Arms of LSSI Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	9 Accumulated Depreciation	
1									1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name: Joshua Arms of LSSI **Report Period Beginning:** 7/1/2015 **Ending:** 6/30/2016

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 $ 846

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	$ 4,143,463	7/1/39		$	1
2											2
3											3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 6,339,159	$ 4,143,463			$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 6,339,159	$ 4,143,463			$ -	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:** 7/1/2015 **Ending:** 6/30/2016

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2016 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 110,155	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	79,853		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)**	$ 190,008	$	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	1,866,534		15
16	Equipment, at Historical Cost	1,034,627		16
17	Accumulated Depreciation (book methods)	(10,664,400)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	476,534		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,441,144	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,631,152	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 355,162	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	485,095		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	See Attached	27,322		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 867,579	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	4,272,763		38
39	Mortgage Payable	1,161,713		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43	See Attached	4,474,764		43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 9,909,240	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 10,776,819	$	45
46	**TOTAL EQUITY**	$ (5,145,667)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 5,631,152	$	47

***(See instructions.)**

Facility Name: Joshua Arms of LSSI **Report Period Beginning: 7/1/2015 Ending: 6/30/2016**

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,296,427	1
2	Discounts and Allowances	(113,300)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,183,127	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	52,691	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 52,691	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**	1,995,873	15
16	**Misc. Income (Adj)**	7,515	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 2,003,388	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 3,239,206	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	501,197	19
20	Health Care/ Personal Care	390,139	20
21	General Administration	437,252	21
	B. Capital Expense		
22	Ownership	2,055,163	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)**	$ 3,383,751	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (144,545)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (144,545)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 801,083	32
33	Private Pay - Net Inpatient Revenue	382,044	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,183,127	37