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: 1000039

Facility Name: Mary Bryant Hm for the 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: 07/08/2004

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: 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 04/01/15 to 03/31/16 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 Drive #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 Hm for the Blind Report Period Beginning: 04/01/15 Ending: 03/31/16

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	11,600	1,116		12,716	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 82.95%

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: 03/31 Fiscal Year: 03/31
* 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 Hm for the Blind **Report Period Beginning: 04/01/15 Ending: 03/31/16**

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	79,292	53,290	1,466	134,048		134,048	1
2	Housekeeping, Laundry and Maintenance	78,553	14,786	51,307	144,645		144,645	2
3	Heat and Other Utilities			109,715	109,715		109,715	3
4	Other (specify):							4
5	**TOTAL General Services**	157,845	68,076	162,488	388,408		388,408	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	220,260	7,912		228,171		228,171	6
7	Activities and Social Services	52,697	6,290	7,075	66,061		66,061	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	272,956	14,201	7,075	294,232		294,232	9
	C. General Administration							
10	Administrative and Clerical	153,206		39,785	192,991		192,991	10
11	Marketing Materials, Promotions and Advertising			57,478	57,478		57,478	11
12	Employee Benefits and Payroll Taxes			164,463	164,463		164,463	12
13	Insurance-Property, Liability and Malpractice			62,837	62,837		62,837	13
14	Other (specify):							14
15	**TOTAL General Administration**	153,206		324,563	477,769		477,769	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	584,007	82,277	494,126	1,160,409		1,160,409	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			91,960	91,960		91,960	17
18	Interest			19,759	19,759		19,759	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			111,719	111,719		111,719	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	584,007	82,277	605,845	1,272,129		1,272,129	24

Facility Name: Mary Bryant Hm for the Blind Report Period Beginning 04/01/15 Ending: 03/31/16

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	18.00	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 Hm for the Blind Report Period Beginning: 04/01/15 Ending: 03/31/16

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		$	$	$ 1,444,230	1
2				2004-2006	539,487	13,487				146,790	2
3											3
4											4
5											5
	Improvement Type										
6	Pavilion, Sign, Lights, Sidewalk, etc.			1991-1994	35,228	743				23,818	6
7	Roof A/C & Coil			2001-2002	17,300					17,300	7
8	A/C Unit			10/26/2007	20,059					20,059	8
9	Dumpster Area Gate			11/11/2008	1,129	57				419	9
10	New Roof			10/25/2010	58,719	2,348				12,722	10
11	Climate Control Upgrade			3/13/2012	35,000	875				3,573	11
12	A/C Chillers			2/28/2013	58,000	1,450				4,471	12
13	Boiler / Chiller			10/15/2013	144,176	9,612				22,895	13
14	Fire / Electrical Upgrade			3/21/2014	8,845	780				1,714	14
15	Heating / Cooling Upgrade			3/31/2015	361,931	9,048				9,048	15
16	Educ. Ctr. Wing Costs			10/31/2014	151,370	3,784				5,361	16
17	TOTAL (lines 1 thru 16)				$ 3,647,458	$ 86,508		$	$	$ 1,712,400	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	$ 3,333	$	-		$ 251,647	18
19	Vehicles	13,045	2,120		-		13,045	19
20	TOTAL (lines 18 and 19)	$ 270,444	$ 5,453	$	$		$ 264,692	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 Hm for the Blind Report Period Beginning: 04/01/15 Ending: 03/31/16

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	$ 115,983	/ /		$	1
2	IL Facilities Fund		X	Mortgage	/ /	418,445	382,870	/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 805,563	$ 498,852			$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 805,563	$ 498,852			$	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 Hm for the Blind **Report Period Beginning:** 04/01/15 **Ending:** 03/31/16

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 03/31/16 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 419,167	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)	6,527		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)**	$ 425,694	$	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	3,655,883		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	284,904		16
17	Accumulated Depreciation (book methods)	(1,977,092)		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)**	$ 2,347,913	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,773,607	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,003	$	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)**	$ 1,003	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	498,852		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)**	$ 498,852	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 499,855	$	45
46	**TOTAL EQUITY**	$ 2,273,752	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 2,773,607	$	47

***(See instructions.)**

Facility Name: Mary Bryant Hm for the Blind **Report Period Beginning: 04/01/15 Ending: 03/31/16**

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	$ 882,555	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 882,555	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	399,613	12
13	Interest and Other Investment Income	58,518	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 458,131	14
	D. Other Revenue (specify):		
15	**Low Vision Store Receipts**	14,644	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 14,644	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,355,330	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	388,408	19
20	Health Care/ Personal Care	294,232	20
21	General Administration	477,769	21
	B. Capital Expense		
22	Ownership	111,719	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)**	$ 1,272,128	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 83,202	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 83,202	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 779,552	32
33	Private Pay - Net Inpatient Revenue	103,003	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 882,555	37