FOR BHF USE

LL2

Supportive Living Facility

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)

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
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Steven N. 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 7/1/2016 to 6/30/2017 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)
**Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum LLP, Nine Parkway North, Suite 200 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: 7/1/2016 Ending: 6/30/2017

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	11,646	2,684		14,330	5
6	Double Unit					6
7	Other					7
8	TOTALS	11,646	2,684		14,330	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 70.11%

D. Indicate the number of paid bed-hold days the SLF had during this year 121 **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)

H. ACCOUNTING BASIS

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

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 6/30/2017 Fiscal Year: 6/30/2017
* 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. N/A

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. N/A

Facility Name: Joshua Arms of LSSI **Report Period Beginning: 7/1/2016 Ending: 6/30/2017**

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	163,808	550	137,479	301,837	(57,364)	244,473	1
2	Housekeeping, Laundry and Maintenance	46,595	45,599	113,081	205,275		205,275	2
3	Heat and Other Utilities							3
4	Other (specify):							4
5	**TOTAL General Services**	210,403	46,149	250,560	507,112	(57,364)	449,748	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	244,478	2,735	35,587	282,800		282,800	6
7	Activities and Social Services	17,906		5,365	23,271		23,271	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	262,384	2,735	40,952	306,071		306,071	9
	C. General Administration							
10	Administrative and Clerical	56,141	3,028	23,860	83,029		83,029	10
11	Marketing Materials, Promotions and Advertising	36,327		1,583	37,910		37,910	11
12	Employee Benefits and Payroll Taxes			297,982	297,982		297,982	12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify):							14
15	**TOTAL General Administration**	92,468	3,028	323,425	418,921		418,921	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	565,255	51,912	614,937	1,232,104	(57,364)	1,174,740	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					298,551	298,551	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			697	697		697	21
22	Other (specify):	433,680	54,748	1,523,918	2,012,346	(2,012,346)		22
23	**TOTAL Ownership**	433,680	54,748	1,524,615	2,013,043	(1,713,795)	299,248	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	998,935	106,660	2,139,552	3,245,147	(1,771,159)	1,473,988	24

Joshua Arms of LSSI

Report Period Beginning: 7/1/2016
Ending: 6/30/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Straight Line Depreciation	$ 298,551	17	1
2	Guest Trays/Employee Meals	(57,364)	01	2
3	Non-Reimbursable Section	(2,012,346)	22	3
4				4
5				5
6				6
7				7
8				8
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95				95
96				96
97				97
98				98
99				99
100				100
101	**Total**	(1,771,159)		101

Facility Name: Joshua Arms of LSSI **Report Period Beginning: 7/1/2016 Ending: 6/30/2017**

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	27.44	2
3	Certified Nurse Assistants	6.32	12.35	3
4	Activity Director & Assistants	0.48	17.80	4
5	Social Service Workers			5
6	Head Cook	2.94	14.98	6
7	Cook Helpers/Assistants	2.87	12.12	7
8	Dishwashers			8
9	Maintenance Workers	0.08	25.46	9
10	Housekeepers	1.67	12.16	10
11	Laundry			11
12	Managers	0.09	51.38	12
13	Other Administrative	0.84	20.56	13
14	Clerical	0.38	13.63	14
15	Marketing	0.81	21.52	15
16	Other	9.50	21.94	16
17	**Total (lines 1 thru 16)**	27.42	$ 17.51	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: 7/1/2016 Ending: 6/30/2017

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	$ 1,433,039	1
2			2007	2007	6,220,763		25	248,831	248,831	2,477,726	2
3											3
4											4
5											5
	Improvement Type										
6	Total From Supplemental Page 5's				263,534			12,947	12,947	124,651	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	Various			1998	2,485		20			2,485	16
17	TOTAL (lines 1 thru 16)				$ 8,201,217	$		$ 298,551	$ 298,551	$ 4,244,933	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	$	$	$	7	$ 243,679	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	$ 243,679	$	$	$		$ 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: 7/1/2016 Ending: 6/30/2017

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	2010	4,313		20	216	216	1,187	2
3	Various	2011	141,949		20	7,097	7,097	78,565	3
4	Hollow Metal Doors, Frames & Hardware	2012	2,714		20	136	136	1,322	4
5	Cla Valve & Associated Components	2014	2,715		20	136	136	408	5
6	Booster Pumps & Associated Components	2014	13,529		20	676	676	2,029	6
7	15 Ptac Units	2014	19,740		20	987	987	2,961	7
8	15 Ptac Units Replacement	2015	20,310		20	1,016	1,016	2,031	8
9	Windows Glass	2015	11,430		20	572	572	1,143	9
10	Removal & Replacement Of Hallway Carpet	2016	11,276		20	564	564	1,128	10
11									11
12									12
13									13
14									14
15									15
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 227,976	$		$ 11,399	$ 11,399	$ 90,773	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: 7/1/2016 Ending: 6/30/2017

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
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
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: 7/1/2016 Ending: 6/30/2017

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
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
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:** 7/1/2016 **Ending:** 6/30/2017

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 $** 697

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			Conversion of 56 unites to assisted living		$ 6,339,159	$ 3,963,307	7/1/39		$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 6,339,159	$ 3,963,307			$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 6,339,159	$ 3,963,307			$	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:** 7/1/2016 **Ending:** 6/30/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2017 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 373,700	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	365,740		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	153,706		6
7	Other Prepaid Expenses	29,319		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 922,465	$	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	1,897,558		15
16	Equipment, at Historical Cost	983,241		16
17	Accumulated Depreciation (book methods)	(11,059,225)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,739,419		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,288,842	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,211,307	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 752,452	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	460,006		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	27,120		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 1,239,578	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,666,613		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43	See Attached	4,066,519		43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 11,733,132	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 12,972,710	$	45
46	**TOTAL EQUITY**	$ (4,761,403)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 8,211,307	$	47

***(See instructions.)**

Facility Name: Joshua Arms of LSSI **Report Period Beginning: 7/1/2016 Ending: 6/30/2017**

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	$ 1,475,392	1
2	Discounts and Allowances	(95,855)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,379,537	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	57,364	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 57,364	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**	2,192,512	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 2,192,512	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 3,629,413	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	507,112	19
20	Health Care/ Personal Care	306,071	20
21	General Administration	418,921	21
	B. Capital Expense		
22	Ownership	2,013,043	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)**	$ 3,245,147	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 384,266	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 384,266	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 127,533	32
33	Private Pay - Net Inpatient Revenue	746,484	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) **Ins - Managed Care**	505,520	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,379,537	37