

		FOR BHF USE			

LL2

Supportive Living Facility

**2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2006)**

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.

<p>I.</p> <p>Facility Name: <u>Mary Bryant Home For The Blind</u></p> <p>Address: <u>2960 Stanton Street</u> <u>Springfield, IL</u> <u>62703</u> <small>Number City Zip Code</small></p> <p>County: <u>Sangamon</u></p> <p>Telephone Number: (<u>217</u>) <u>529-1611</u> Fax # <u>217 529-6975</u></p> <p>Federal Employer ID Number: <u>37-0673464</u></p> <p>Date Current Owners were Certified: <u>7-08-2004</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Joe Brockamp</u> Telephone Number: (<u>217</u>) <u>793-3363</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>04/01/05</u> to <u>03/31/06</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Jerry Curry</u></td> <td></td> </tr> <tr> <td></td> <td colspan="2">(Title) <u>Administrator</u></td> </tr> <tr> <td rowspan="4" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Joe Brockamp</u> <u>Accountant</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>Sikich, LLP</u> <u>1000 Churchill Road, Springfield, IL 62702</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>217 793-3363</u> Fax <u>217-862-3135</u></td> <td></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Jerry Curry</u>			(Title) <u>Administrator</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Joe Brockamp</u> <u>Accountant</u>		(Firm Name & Address) <u>Sikich, LLP</u> <u>1000 Churchill Road, Springfield, IL 62702</u>		(Telephone) <u>217 793-3363</u> Fax <u>217-862-3135</u>	
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Facility Name: Mary Bryant Home For The Blind

Report Period Beginning:

04/01/05

Ending:

03/31/06

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	46,377	45,336		91,713		91,713	1
2	Housekeeping, Laundry and Maintenance	78,631	14,616	60,969	154,216		154,216	2
3	Heat and Other Utilities			71,582	71,582		71,582	3
4	Other (specify):							4
5	TOTAL General Services	125,008	59,952	132,551	317,511		317,511	5
B. Health Care and Programs								
6	Health Care/ Personal Care	168,085		640	168,725		168,725	6
7	Activities and Social Services	44,303	3,392	6,698	54,393		54,393	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	212,388	3,392	7,338	223,118		223,118	9
C. General Administration								
10	Administrative and Clerical	107,031		38,781	145,812		145,812	10
11	Marketing Materials, Promotions and Advertising			4,040	4,040		4,040	11
12	Employee Benefits and Payroll Taxes			90,854	90,854		90,854	12
13	Insurance-Property, Liability and Malpractice			53,312	53,312		53,312	13
14	Other (specify):							14
15	TOTAL General Administration	107,031		186,987	294,018		294,018	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	444,427	63,344	326,876	834,647		834,647	16
Capital Expenses								
D. Ownership								
17	Depreciation			58,660	58,660		58,660	17
18	Interest			48,905	48,905		48,905	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			107,565	107,565		107,565	23
24	GRAND TOTAL (Sum of lines 16 and 23)	444,427	63,344	434,441	942,212		942,212	24

Facility Name: Mary Bryant Home For The Blind

Report Period Beginning: 04/01/05 Ending: 03/31/06

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 20.00	1
2	Licensed Practical Nurses	1	14.00	2
3	Certified Nurse Assistants	5	9.00	3
4	Activity Director & Assistants	2	10.00	4
5	Social Service Workers	1	20.00	5
6	Head Cook	1	10.00	6
7	Cook Helpers/Assistants	2	9.00	7
8	Dishwashers			8
9	Maintenance Workers	2	7.00	9
10	Housekeepers	2	9.00	10
11	Laundry			11
12	Managers	1	26.00	12
13	Other Administrative	1	14.00	13
14	Clerical	1	13.00	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	None			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	None	\$
2		
Total		\$

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 <u>1</u>	City <u>2</u>

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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

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

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).

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Report Period Beginning: 04/01/05

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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	18			1982-1983	\$ 2,216,214	\$ 44,324	50	\$	\$	\$ 1,000,987	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Pavilion		Aug-91	28,791	720	40			10,558	6
7		Sidewalks		Jun-92	3,927	197	20			2,698	7
8		Remodeling		Oct-92	898	23	40			299	8
9		Sign		Dec-93	988		10			988	9
10		Outdoor Lights		Jan-94	624		10			624	10
11		A/C Coil		May-01	11,300	994	7			8,814	11
12		Roof A/C		Apr-02	6,000	858	7			3,429	12
13		Supportive Living Construction - Phase 1		Sep-04	387,565	9,689	40			14,220	13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 2,656,307	\$ 56,805		\$	\$	\$ 1,042,617	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	\$ 223,496	\$ 1,855	\$	(1,855)		\$ 220,123	18
19	Vehicles	50,615					50,615	19
20	TOTAL (lines 18 and 19)	\$ 274,111	\$ 1,855	\$	(1,855)		\$ 270,738	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

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IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	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	2	3	4	6	7	8	9		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related Long-Term									
1	Chase Bank			Mortgage	/ /	\$ 1,500,000	\$ 578,654	/ /		\$ 27,570
2	IL Facilities Fund			Mortgage	/ /	387,118	361,224	/ /		21,335
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 1,887,118	\$ 939,878			\$ 48,905
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 1,887,118	\$ 939,878			\$ 48,905

* 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.

STATE OF ILLINOIS

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Facility Name: Mary Bryant Home For The Blind

Report Period Beginning: 04/01/05

Ending:

03/31/06

03/31/06

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/06

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 252,306	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			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)	\$ 252,306	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	15,448		12
13	Land	147,030		13
14	Buildings, at Historical Cost	2,656,307		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	274,111		16
17	Accumulated Depreciation (book methods)	(1,313,355)		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): Construction in Progress	8,305		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,787,846	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,040,152	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	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	3,323		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)	\$ 3,323	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	939,878		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)	\$ 939,878	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 943,201	\$	45
46	TOTAL EQUITY	\$ 1,096,951	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,040,152	\$	47

*(See instructions.)

Facility Name: Mary Bryant Home For The Blind

Report Period Beginning: 04/01/05

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03/31/06

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 558,020	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 558,020	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	319,770	12
13	Interest and Other Investment Income	7,307	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 327,077	14
D. Other Revenue (specify):			
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 885,097	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	317,511	19
20	Health Care/ Personal Care	223,118	20
21	General Administration	294,018	21
B. Capital Expense			
22	Ownership	107,565	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)	\$ 942,212	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (57,115)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (57,115)	31