FOR BHF USE

LL2

Supportive Living Facility

2009

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2009)

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 Name: Mary Bryant Home for the Blind

Address: 2960 Stanton Avenue (Number) Springfield (City) 62703 (Zip Code)

County: Sangamon

Telephone Number: (217) 529-1611 **Fax #** ( )

Federal Employer ID Number: 37-0673464

Date Current Owners were Certified: 7/08/2004

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: Joe Brockamp **Telephone Number:** (217 793-3363
Email Address: jbrockamp@sikich.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 04/01/2008 to 03/31/2009 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) Joe Brockamp, Treasurer
(Firm Name & Address) Sikich, LLP, 1000 Churchill Road Springfield, IL 62702
(Telephone) 217) 793-3363 Fax 217-862-3135

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 for the Blind Report Period Beginning: 04/01/2008 Ending: 03/31/2009

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		15,330	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	12,085	2,646		14,731	6
7	Other					7
8	TOTALS	12,085	2,646		14,731	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.09%

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? Yes **If yes, did the facility make all of the required payments of interest and principle?** Yes
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 for the Blind **Report Period Beginning: 04/01/2008 Ending: 03/31/2009**

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	67,427	69,807	888	138,122		138,122	1
2	Housekeeping, Laundry and Maintenance	94,613	16,899	52,898	164,410		164,410	2
3	Heat and Other Utilities			98,288	98,288		98,288	3
4	Other (specify):							4
5	**TOTAL General Services**	162,040	86,706	152,074	400,820		400,820	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	181,284	4,191		185,475		185,475	6
7	Activities and Social Services	39,491	43,120	1,353	83,964		83,964	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	220,775	47,311	1,353	269,439		269,439	9
	C. General Administration							
10	Administrative and Clerical	122,253		38,680	160,933		160,933	10
11	Marketing Materials, Promotions and Advertising			1,286	1,286		1,286	11
12	Employee Benefits and Payroll Taxes			96,880	96,880		96,880	12
13	Insurance-Property, Liability and Malpractice			31,102	31,102		31,102	13
14	Other (specify):							14
15	**TOTAL General Administration**	122,253		167,948	290,201		290,201	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	505,068	134,017	321,375	960,460		960,460	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			67,720	67,720		67,720	17
18	Interest			34,483	34,483		34,483	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			102,203	102,203		102,203	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	505,068	134,017	423,578	1,062,663		1,062,663	24

Facility Name: Mary Bryant Home for the Blind **Report Period Beginning: 04/01/2008 Ending: 03/31/2009**

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	10.00	3
4	Activity Director & Assistants	2	11.00	4
5	Social Service Workers	1	20.00	5
6	Head Cook	1	11.00	6
7	Cook Helpers/Assistants	2	10.00	7
8	Dishwashers			8
9	Maintenance Workers	2	10.00	9
10	Housekeepers	2	10.00	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				$	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 for the Blind **Report Period Beginning:** 04/01/2008 **Ending:** 03/31/2009

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		$	$	$ 1,133,960	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Pavilion			Aug-91	28,791	720				12,718	6
7	Sidewalks			Jun-92	3,927	196				3,287	7
8	Remodeling			Oct-92	898	22				366	8
9	Outdoor Sign			Dec-93	988					988	9
10	Outdoor Lighting			Jan-94	624					624	10
11	A/C Coil			May-01	11,300	497				11,300	11
12	Roof Air Conditioner			Apr-02	6,000	857				6,000	12
13	Supportive Living Construction - Phase I			Sep-04	387,565	9,689				43,288	13
14	Supportive Living Construction - Phase II			Oct-06	151,922	3,798				9,092	14
15	A/C Unit			Oct-07	20,059	4,912				7,778	15
16	Dumpster Area Gate			Nov-08	1,129	24				24	16
17	TOTAL (lines 1 thru 16)				$ 2,829,417	$ 65,039		$	$	$ 1,229,425	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	$ 225,578	$ 1,583	$			$ 224,261	18
19	Vehicles	18,003	1,098				17,455	19
20	TOTAL (lines 18 and 19)	$ 243,581	$ 2,681	$	$		$ 241,716	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 for the Blind Report Period Beginning: 04/01/2008 Ending: 3/31/2009

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 $

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	Chase Bank			Mortgage	/ /	$ 1,500,000	$ 390,839	/ /		$ 16,481	1
2	IL Facilities Fund			Mortgage	/ /	387,118	301,785	/ /		17,999	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 1,887,118	$ 692,624			$ 34,480	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 1,887,118	$ 692,624			$ 34,480	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 for the Blind **Report Period Beginning:** 04/01/2008 **Ending:** 03/31/2009

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 03/31/2009 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 67,560	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced Cost)	7,769		4
5	Short-Term Investments	15,529		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)**	$ 90,858	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	147,030		13
14	Buildings, at Historical Cost	2,829,417		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	243,582		16
17	Accumulated Depreciation (book methods)	(1,471,142)		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)**	$ 1,748,887	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,839,745	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 154	$	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)**	$ 154	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	692,624		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)**	$ 692,624	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 692,778	$	45
46	**TOTAL EQUITY**	$ 1,146,967	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 1,839,745	$	47

***(See instructions.)**

Facility Name: Mary Bryant Home for the Blind **Report Period Beginning: 04/01/2008 Ending: 03/31/2009**

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	$ 984,264	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 984,264	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	79,894	12
13	Interest and Other Investment Income	1,733	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 81,627	14
	D. Other Revenue (specify):		
15		7,256	15
16		49,432	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 56,688	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,122,579	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	400,820	19
20	Health Care/ Personal Care	269,439	20
21	General Administration	290,201	21
	B. Capital Expense		
22	Ownership	102,203	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)**	$ 1,062,663	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 59,916	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 59,916	31