

		FOR BHF USE			

LL2

Supportive Living Facility

**2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2012)**

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. Facility ID Number: <u>1000039</u></p> <p>Facility Name: <u>Mary Bryant Home for the Blind</u></p> <p>Address: <u>2960 Stanton Avenue</u> <u>Springfield</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: _____</p> <p>Date Current Owners were Certified: <u>7/8/2004</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> Email Address: _____</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>4/1/11</u> to <u>3/31/12</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%;">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>(Title) <u>Administrator</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Joe Brockamp</u> <u>Treasurer</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>Sikich LLP</u> <u>3201 W White Oaks Dr, Ste 102, Spfld, IL 62704</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>217 793-3363</u> Fax <u>217-793-3016</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>Treasurer</u>		(Firm Name & Address) <u>Sikich LLP</u> <u>3201 W White Oaks Dr, Ste 102, Spfld, IL 62704</u>		(Telephone) <u>217 793-3363</u> Fax <u>217-793-3016</u>	
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Facility Name Mary Bryant Home for the Blind

Report Period Beginning: 4/1/11 Ending: 3/31/12

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1		Single Unit Apartment			1
2		Double Unit Apartment			2
3		Other			3
4		TOTALS		15,372	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
5	Single Unit				5	
6	Double Unit				6	
7	Other				7	
8	TOTALS	11,775	736		12,511	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 81.39%

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

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES 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 MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? 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? 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 Home for the Blind

Report Period Beginning:

4/1/11

Ending:

3/31/12

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	70,063	64,970	1,038	136,071		136,071	1
2	Housekeeping, Laundry and Maintenance	64,644	14,840	71,828	151,312		151,312	2
3	Heat and Other Utilities			114,370	114,370		114,370	3
4	Other (specify):							4
5	TOTAL General Services	134,707	79,810	187,236	401,753		401,753	5
B. Health Care and Programs								
6	Health Care/ Personal Care	174,256	5,523		179,779		179,779	6
7	Activities and Social Services	61,355	47,808	1,480	110,643		110,643	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	235,611	53,331	1,480	290,422		290,422	9
C. General Administration								
10	Administrative and Clerical	132,717		45,128	177,845		177,845	10
11	Marketing Materials, Promotions and Advertising	8,064		18,376	26,440		26,440	11
12	Employee Benefits and Payroll Taxes			89,726	89,726		89,726	12
13	Insurance-Property, Liability and Malpractice			37,975	37,975		37,975	13
14	Other (specify):							14
15	TOTAL General Administration	140,781		191,205	331,986		331,986	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	511,099	133,141	379,921	1,024,161		1,024,161	16
Capital Expenses								
D. Ownership								
17	Depreciation			69,571	69,571		69,571	17
18	Interest			15,521	15,521		15,521	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			85,092	85,092		85,092	23
24	GRAND TOTAL (Sum of lines 16 and 23)	511,099	133,141	465,013	1,109,253		1,109,253	24

Facility Name: Mary Bryant Home for the Blind

Report Period Beginning 4/1/11

Ending:

3/31/12

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 21.00	1
2	Licensed Practical Nurses	1	14.00	2
3	Certified Nurse Assistants	5	11.00	3
4	Activity Director & Assistants	2	12.00	4
5	Social Service Workers	1	11.00	5
6	Head Cook	1	13.00	6
7	Cook Helpers/Assistants	2	11.00	7
8	Dishwashers			8
9	Maintenance Workers	2	14.00	9
10	Housekeepers	1	10.00	10
11	Laundry	1	9.00	11
12	Managers	1	31.00	12
13	Other Administrative	1	18.00	13
14	Clerical	1	17.00	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

		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

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).

Facility Name: Mary Bryant Home for the Blind

Report Period Beginning: 4/1/11

Ending: 3/31/12

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		\$	\$	\$ 1,266,933	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Pavillion		8/6/1991	28,791	720				14,877	6
7		Sidewalks		6/30/1992	3,927	196				3,876	7
8		Remodeling		10/21/1992	898	22				433	8
9		Outdoor Sign & Lights		1/19/1994	1,612					1,612	9
10		A/C Coil		5/23/2001	11,300					11,300	10
11		Roof A/C		4/1/2002	6,000					6,000	11
12		Supportive Living Construction		2004-2006	539,487	13,487				92,841	12
13		A/C Unit		10/26/2007	20,059	1,790				15,583	13
14		Dumpster Area Gate		11/11/2008	1,129	57				193	14
15		New Roof		10/25/2010	58,719	2,348				3,327	15
16		Climate Control Upgrade		3/13/2012	35,000	73				73	16
17		TOTAL (lines 1 thru 16)			\$ 2,923,136	\$ 63,017		\$	\$	\$ 1,417,048	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	\$ 249,534	\$ 6,554	\$			\$ 237,509	18
19	Vehicles	18,003					18,003	19
20	TOTAL (lines 18 and 19)	\$ 267,537	\$ 6,554	\$	\$		\$ 255,512	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: 4/1/11

Ending: 3/31/12

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	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		X	Mortgage	/ /	\$ 1,500,000	\$ 154,134	/ /		\$ 4,598
2	IL Facilities Fund		X	Mortgage	/ /	387,118	230,976	/ /		10,923
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 1,887,118	\$ 385,110			\$ 15,521
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 1,887,118	\$ 385,110			\$ 15,521

* 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: 4/1/11

Ending:

3/31/12

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 3/31/12

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 93,611	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced :cost)	12,690		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)	\$ 106,301	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	158,083		12
13	Land	147,030		13
14	Buildings, at Historical Cost	2,923,136		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	267,537		16
17	Accumulated Depreciation (book methods)	(1,672,561)		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)	\$ 1,823,225	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,929,526	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 329	\$	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)	\$ 329	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	385,110		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)	\$ 385,110	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 385,439	\$	45
46	TOTAL EQUITY	\$ 1,544,087	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,929,526	\$	47

*(See instructions.)

Facility Name: Mary Bryant Home for the Blind

Report Period Beginning: 4/1/11

Ending:

3/31/12

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	\$ 898,624	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 898,624	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	186,026	12
13	Interest and Other Investment Income	2,104	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 188,130	14
D. Other Revenue (specify):			
15		47,271	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 47,271	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,134,025	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	401,753	19
20	Health Care/ Personal Care	290,422	20
21	General Administration	331,986	21
B. Capital Expense			
22	Ownership	85,092	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)	\$ 1,109,253	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 24,772	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 24,772	31

