

FOR BHF USE							

LL2

Supportive Living Facility
2019
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2019)

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 Home for Blind

Address: 2960 Stanton Avenue Springfield 62703
 Number City 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
☒ 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 04/01/18 to 03/31/19
 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 Dr #102 Springfield, IL 62704

(Telephone) 217) 793-3363 Fax 217-862-3134

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 BlindReport Period Beginning: 04/01/18 Ending: 03/31/19

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		15,330	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	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	11,555	1,694		13,249	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 86.43%

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 ☐ NOTax 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 principal? 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 principal? 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 principal? If no, explain.

STATE OF ILLINOIS

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Facility Name: Mary Bryant Home for Blind

Report Period Beginning:

04/01/18

Ending:

03/31/19

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	101,014	51,343	1,280	153,637		153,637	1
2	Housekeeping, Laundry and Maintenance	107,395	28,164	85,285	220,844		220,844	2
3	Heat and Other Utilities			112,056	112,056		112,056	3
4	Other (specify):							4
5	TOTAL General Services	208,409	79,507	198,621	486,537		486,537	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	281,083	6,705		287,788		287,788	6
7	Activities and Social Services	82,104	4,503	4,868	91,475		91,475	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	363,187	11,208	4,868	379,263		379,263	9
	C. General Administration							
10	Administrative and Clerical	154,937		45,500	200,437		200,437	10
11	Marketing Materials, Promotions and Advertising			19,750	19,750		19,750	11
12	Employee Benefits and Payroll Taxes			201,435	201,435		201,435	12
13	Insurance-Property, Liability and Malpractice			39,361	39,361		39,361	13
14	Other (specify):							14
15	TOTAL General Administration	154,937		306,046	460,983		460,983	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	726,533	90,715	509,535	1,326,783		1,326,783	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			92,801	92,801		92,801	17
18	Interest			11,319	11,319		11,319	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			104,120	104,120		104,120	23
24	GRAND TOTAL (Sum of lines 16 and 23)	726,533	90,715	613,655	1,430,903		1,430,903	24

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 24.00	1
2	Licensed Practical Nurses	1	18.50	2
3	Certified Nurse Assistants	5	14.00	3
4	Activity Director & Assistants	1	18.00	4
5	Social Service Workers	1	14.00	5
6	Head Cook	1	17.00	6
7	Cook Helpers/Assistants	2	14.00	7
8	Dishwashers	1	10.00	8
9	Maintenance Workers	1	22.00	9
10	Housekeepers	1	11.00	10
11	Laundry	1	10.00	11
12	Managers	1	36.00	12
13	Other Administrative	2	16.00	13
14	Clerical	1	11.00	14
15	Marketing	1	17.00	15
16	Other			16
17	Total (lines 1 thru 16)	21	\$	17

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).

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

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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				1982-1983	\$ 2,216,214	\$ 44,324		\$	(44,324)	\$ 1,577,203	1
2				2004-2006	539,487	13,487			(13,487)	187,252	2
3											3
4											4
5											5
Improvement Type											
6		Pavilion, Sign, Lights, Sidewalk, etc.		1991-1994	32,718	719			(719)	23,842	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	56			(56)	588	9
10		New Roof		10/25/2010	58,719	2,349			(2,349)	19,769	10
11		Climate Control Upgrade		3/13/2012	35,000	875			(875)	6,198	11
12		A/C Chillers		2/28/2013	58,000	1,450			(1,450)	8,821	12
13		Boiler / Chiller		10/15/2013	146,686	9,634			(9,634)	53,932	13
14		Fire / Electrical Upgrade		3/21/2014	8,845	780			(780)	4,055	14
15		Heating / Cooling Upgrade		3/31/2015	370,356	9,259			(9,259)	36,614	15
16		Educ. Ctr. Wing Costs		10/31/2014	151,370	3,784			(3,784)	16,714	16
17		TOTAL (lines 1 thru 16)			\$ 3,655,883	\$ 86,717		\$	(86,717)	\$ 1,972,347	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	\$ 289,427	\$ 4,418	\$	(4,418)		\$ 259,845	18
19	Vehicles	14,460	1,666		(1,666)		11,962	19
20	TOTAL (lines 18 and 19)	\$ 303,887	\$ 6,084	\$	(6,084)		\$ 271,807	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	IL Facilities Fund		X	Mortgage	10/1/14	\$ 387,118	\$ 20,113	/ /	2.7500	\$ 1,058	1	
2	IL Facilities Fund		X	Mortgage	4/8/15	418,445	271,715	/ /	3.5000	10,261	2	
3					/ /			/ /			3	
	Working Capital											
4					/ /			/ /			4	
5					/ /			/ /			5	
6					/ /			/ /			6	
7	TOTAL Facility Related					\$ 805,563	\$ 291,828				\$ 11,319	7
	B. Non-Facility Related											
8					/ /			/ /			8	
9					/ /			/ /			9	
10	TOTALS (lines 7, 8 and 9)					\$ 805,563	\$ 291,828				\$ 11,319	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.

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/19

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 422,384	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced at)	10,612		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)	\$ 432,996	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	633,684		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	303,887		16
17	Accumulated Depreciation (book methods)	(2,244,155)		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)	\$ 2,496,329	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,929,325	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 713	\$	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)	\$ 713	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	291,828		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)	\$ 291,828	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 292,541	\$	45
46	TOTAL EQUITY	\$ 2,636,784	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,929,325	\$	47

*(See instructions.)

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

		1	
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,106,423	1
2	Discounts and Allowances		2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 1,106,423	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
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$	11
	C. Non-Operating Revenue		
12	Contributions	479,384	12
13	Interest and Other Investment Income	51,486	13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$ 530,870	14
	D. Other Revenue (specify):		
15	Low Vision Store Receipts	5,652	15
16			16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$ 5,652	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 1,642,945	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	486,538	19
20	Health Care/ Personal Care	379,263	20
21	General Administration	460,983	21
	B. Capital Expense		
22	Ownership	104,120	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 1,430,904	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ 212,041	29
	Income Taxes		
30		\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ 212,041	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 990,692	32
33	Private Pay - Net Inpatient Revenue	115,731	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,106,423	37