

		FOR BHF USE			

LL2

Supportive Living Facility

2021

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2021)

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 Joliet 60433 <div>Number City Zip Code</div> 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: <div> <div> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <div> <input checked="" type="checkbox"/> Charitable Corp. <div> <input type="checkbox"/> Trust </div> </div> </div> <div> <input type="checkbox"/> PROPRIETARY <div> <input type="checkbox"/> Individual <div> <input type="checkbox"/> Partnership </div> <input type="checkbox"/> Corporation <div> <input type="checkbox"/> "Sub-S" Corp. </div> <input type="checkbox"/> Limited Liability Co. <div> <input type="checkbox"/> Trust </div> <input type="checkbox"/> Other <div></div> </div> </div> <div> <input type="checkbox"/> GOVERNMENTAL <div> <input type="checkbox"/> State <div> <input type="checkbox"/> County </div> <input type="checkbox"/> Other <div></div> </div> </div> </div> <div> IRS Exemption Code _____ </div>				
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Facility Name Joshua Arms of LSSIReport Period Beginning: 7/1/2020 Ending: 6/30/2021**III. STATISTICAL DATA****A. Certified units; enter number of units and unit days**Date of change in certified units N/A

	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	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	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	12,209	365		12,574	5
6	Double Unit					6
7	Other					7
8	TOTALS	12,209	365		12,574	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 61.52%

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

115 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 0 (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**

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☒ YES ☐ NOTax Year: 06/30/2021 Fiscal Year: 06/30/2021

* 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. 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 principal? 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 principal? If no, explain. N/A

STATE OF ILLINOIS

Page 3

Facility Name: Joshua Arms of LSSI

Report Period Beginning:

7/1/2020

Ending:

6/30/2021

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	101,607		133,582	235,189	(47,819)	187,370	1
2	Housekeeping, Laundry and Maintenance	146,639	3,558	36,334	186,531		186,531	2
3	Heat and Other Utilities			48,903	48,903		48,903	3
4	Other (specify):							4
5	TOTAL General Services	248,246	3,558	218,819	470,623	(47,819)	422,804	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	128,868	1,598	154,038	284,504		284,504	6
7	Activities and Social Services	137,355		101,791	239,146		239,146	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	266,223	1,598	255,829	523,650		523,650	9
	C. General Administration							
10	Administrative and Clerical	42,146	2,882	102,155	147,183	(83,569)	63,615	10
11	Marketing Materials, Promotions and Advertising	22,550		405	22,955		22,955	11
12	Employee Benefits and Payroll Taxes			283,415	283,415		283,415	12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify):							14
15	TOTAL General Administration	64,696	2,882	385,975	453,553	(83,569)	369,985	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	579,165	8,038	860,623	1,447,826	(131,388)	1,316,438	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					260,229	260,229	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			232	232		232	21
22	Other (specify):	508,201	61,891	2,703,165	3,273,257	(3,273,257)		22
23	TOTAL Ownership	508,201	61,891	2,703,397	3,273,489	(3,013,028)	260,461	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,087,366	69,929	3,564,020	4,721,315	(3,144,415)	1,576,900	24

STATE OF ILLINOIS		Page 3A
Joshua Arms of LSSI		
Report Period Beginning:	7/1/2020	
Ending:	6/30/2021	
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1 Non-Straight Line Depreciation	\$ 260,229	17 1
2 Guest Travel/Employee Meals	(47,819)	01 2
3 Bad Debt Expense	(14,482)	10 3
4 Non-Reimbursable Section	(3,273,257)	22 4
5 HUD Management Fees	(69,087)	10 5
6		6
7		7
8		8
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98		98
99		99
100		100
101 Total	(3,144,415)	101

Facility Name: Joshua Arms of LSSI

Report Period Beginning 7/1/2020 Ending: 6/30/2021

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	0.53	29.19	2
3	Certified Nurse Assistants	3.20	14.53	3
4	Activity Director & Assistants	0.57	16.46	4
5	Social Service Workers	2.13	26.67	5
6	Head Cook	1.98	15.04	6
7	Cook Helpers/Assistants	1.61	11.83	7
8	Dishwashers			8
9	Maintenance Workers	3.38	18.79	9
10	Housekeepers	0.85	8.26	10
11	Laundry			11
12	Managers			12
13	Other Administrative	0.61	19.20	13
14	Clerical	0.62	13.93	14
15	Marketing	0.53	20.39	15
16	Other	14.03	17.41	16
17	Total (lines 1 thru 16)	30.03	\$ 17.41	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
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 ☒

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	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

Facility Name: Joshua Arms of LSSI

Report Period Beginning:

7/1/2020

Ending:

6/30/2021

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	\$ 1,470,916	\$	1,470,916	1
2			2007	2007	6,220,763		25	248,831	248,831	3,473,050	2
3											3
4											4
5											5
Improvement Type											
6	Total From Supplemental Page 5's				263,534		20	11,399	11,399	171,926	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	\$		\$ 1,731,145	\$ 260,229	\$ 5,325,410	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	\$	\$	\$		\$ 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	Moveable Equipment	\$ 786,839	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 786,839	\$	\$	24

XI. OWNERSHIP COSTS (continued)
B. Building and Improvement Costs-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	Cla Valve & Associated Components	2014	2,715		20	136	136	951	1
2	Booster Pumps & Associated Components	2014	13,529		20	676	676	4,735	2
3	15 Ptac Units	2014	19,740		20	987	987	6,909	3
4	15 Ptac Units Replacement	2015	20,310		20	1,016	1,016	6,093	4
5	Windows Glass	2015	11,430		20	572	572	3,429	5
6	Removal & Replacement Of Hallway Carpet	2016	11,276		20	564	564	3,383	6
7									7
8									8
9									9
10									10
11									11
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15									15
16									16
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 79,000	\$		\$ 3,950	\$ 3,950	\$ 25,499	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
B. Building and Improvement Costs-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
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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.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
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.

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		8. Is movable equipment rental included in building rental?
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*		<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Original Building			/ /	\$			3	9. Rental amount for movable equipment \$ 232
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 \$ 232

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	Assisted Living Conversion			Conversion of 56 units to Assisted Livin	/ /	\$ 6,339,159	\$ 3,602,995	7/1/39		\$	1	
2					/ /			/ /			2	
3					/ /			/ /			3	
	Working Capital											
4					/ /			/ /			4	
5					/ /			/ /			5	
6					/ /			/ /			6	
7	TOTAL Facility Related					\$ 6,339,159	\$ 3,602,995				\$	7
	B. Non-Facility Related											
8					/ /			/ /			8	
9					/ /			/ /			9	
10	TOTALS (lines 7, 8 and 9)					\$ 6,339,159	\$ 3,602,995				\$	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.

STATE OF ILLINOIS

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Facility Name: Joshua Arms of LSSI

Report Period Beginning: 7/1/2020

Ending: 6/30/2021

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2021

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 122,088	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	491,108		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,421		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 619,617	\$	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	1,710,573		15
16	Equipment, at Historical Cost	1,042,069		16
17	Accumulated Depreciation (book methods)	(11,406,457)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,846,684		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	12,580		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,933,298	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,552,915	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 411,647	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	131,033		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	19,946		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36	See Attached	424,625		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 987,251	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,728,107		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43	See Attached	3,714,576		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 10,442,683	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 11,429,934	\$	45
46	TOTAL EQUITY	\$ (4,877,019)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,552,915	\$	47

*(See instructions.)

Facility Name: Joshua Arms of LSSI

Report Period Beginning: 7/1/2020

Ending:

6/30/2021

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	\$ 1,766,133	1
2	Discounts and Allowances	(144,225)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,621,908	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	47,819	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 47,819	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	See Attached	353,826	15
16	Non-Reimbursable Section	2,243,140	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 2,596,966	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,266,693	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	470,623	19
20	Health Care/ Personal Care	523,650	20
21	General Administration	453,553	21
	B. Capital Expense		
22	Ownership	3,273,489	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)	\$ 4,721,315	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (454,622)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (454,622)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ (36,552)	32
33	Private Pay - Net Inpatient Revenue	675,124	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Ins - Managed Care</u>	983,336	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,621,908	37