

		FOR BHF USE			

LL2

**Supportive Living Facility**  
**2017**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE & FAMILY SERVICES**  
**COST REPORT FOR**  
**SUPPORTIVE LIVING FACILITIES**  
**(FISCAL YEAR 2017)**

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><b>I. Facility ID Number:</b> <u>1000127</u></p> <p><b>Facility Name:</b> <u>The Glenwood of Mt Zion</u></p> <hr/> <p><b>Address:</b> <u>1635 Baltimore Ave</u> <u>Mt Zion</u> <u>62459</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>Macon</u></p> <p><b>Telephone Number:</b> ( <u>217 864-1073</u> Fax # <u>217 864-1077</u> )</p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>2014</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input 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><b>IRS Exemption Code</b> _____</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 checked="" 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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Shelley Welch</u> <b>Telephone Number:</b> ( <u>217 821-9539</u> )  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2017</u> to <u>12/31/2017</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 style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Shelley Welch</u></td> </tr> <tr> <td></td> <td>(Title) <u>Director of Operations</u></td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) ( <u>    </u> ) _____ Fax # ( <u>    </u> ) _____</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>Shelley Welch</u>		(Title) <u>Director of Operations</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) ( <u>    </u> ) _____ Fax # ( <u>    </u> ) _____
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	(Telephone) ( <u>    </u> ) _____ Fax # ( <u>    </u> ) _____																																						

Facility Name The Glenwood of Mt Zion

Report Period Beginning: 2017 Ending: 2017

**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	37	Single Unit Apartment	37	13,505	1
2	1	Double Unit Apartment	1	365	2
3		Other			3
4	38	TOTALS	38	13,870	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	4,194	8,443		12,637	5
6	Double Unit		234		234	6
7	Other					7
8	TOTALS	4,194	8,677		12,871	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.80%

**D. Indicate the number of paid bed-hold days the SLF had during this year**  
8 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 46 (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)

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**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

**I. Is your fiscal year identical to your tax year?**  YES  NO  
 Tax Year: 2017 Fiscal Year: 2017

\* 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: The Glenwood of Mt Zion

Report Period Beginning:

1/1/2017

Ending: 12/31/2017

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	67,223	111,451	6,237	184,911		184,911	1
2	Housekeeping, Laundry and Maintenance	20,599	44,216	16,818	81,633		81,633	2
3	Heat and Other Utilities			114,107	114,107		114,107	3
4	Other (specify): Fire Inspection Testing			1,241	1,241		1,241	4
5	<b>TOTAL General Services</b>	87,822	155,667	138,402	381,892		381,892	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	259,083	1,439	2,643	263,166		263,166	6
7	Activities and Social Services		272	5,095	5,367		5,367	7
8	Other (specify): Training & Education			2,477	2,477		2,477	8
9	<b>TOTAL Health Care and Programs</b>	259,083	1,712	10,215	271,010		271,010	9
<b>C. General Administration</b>								
10	Administrative and Clerical	65,869	3,323	107,780	176,972		176,972	10
11	Marketing Materials, Promotions and Advertising		2,068	19,381	21,449		21,449	11
12	Employee Benefits and Payroll Taxes	76,392		1,975	78,367		78,367	12
13	Insurance-Property, Liability and Malpractice			20,302	20,302		20,302	13
14	Other (specify): Auto Fuel/Mnt Exp & Bad Debt			7,216	7,216		7,216	14
15	<b>TOTAL General Administration</b>	142,260	5,391	156,655	304,306		304,306	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	489,166	162,770	305,272	957,208		957,208	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			25,318	25,318		25,318	17
18	Interest							18
19	Real Estate Taxes			109,709	109,709		109,709	19
20	Rent -- Facility and Grounds			299,992	299,992		299,992	20
21	Rent -- Equipment							21
22	Other (specify): Minor Furniture & Fixtures			1,047	1,047		1,047	22
23	<b>TOTAL Ownership</b>			436,066	436,066		436,066	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	489,166	162,770	741,338	1,393,274		1,393,274	24

Facility Name: The Glenwood of Mt Zion

Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 23.50	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	4	10.10	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	10.35	6
7	Cook Helpers/Assistants	2	9.25	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	9.50	10
11	Laundry			11
12	Managers	1	19.58	12
13	Other Administrative	1	12.03	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>11</b>	<b>\$</b>	<b>17</b>

**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
<b>Total</b>				<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$ 3</b>

**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
GAHCR II Mt. Zion ALF TRS		Irvine, CA			
Senior Health Specialties, Inc		Effingham, IL			

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: The Glenwood of Mt Zion

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land \_\_\_\_\_ Year land was acquired \_\_\_\_\_

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					\$	\$		\$	\$	\$	1
2											2
3											3
4											4
5											5
	Improvement Type										
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$	\$		\$	\$	\$	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	\$	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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: The Glenwood of Mt Zion

Report Period Beginning: 1/1/2017

Ending: 2/31/2017

**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: Northstar

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	2009	38	11/1/2014	\$ 24,999			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	<b>TOTAL</b>		38		\$ 24,999			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		3	4	6		7	8	9		
			Related**				Purpose of Loan	Date of Note					Amount of Note
			YES	NO			Original	Balance					
		<b>A. Directly Facility Related</b>											
		<b>Long-Term</b>											
1						/ /	\$	\$	/ /			1	
2						/ /			/ /			2	
3						/ /			/ /			3	
		<b>Working Capital</b>											
4						/ /			/ /			4	
5						/ /			/ /			5	
6						/ /			/ /			6	
7		<b>TOTAL Facility Related</b>						\$	\$			\$	7
		<b>B. Non-Facility Related</b>											
8						/ /			/ /			8	
9						/ /			/ /			9	
10		<b>TOTALS (lines 7, 8 and 9)</b>						\$	\$			\$	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: The Glenwood of Mt Zion

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 55,269	\$	1
2	Cash-Patient Deposits	33,320		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	68,654		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,503		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 168,746	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	189,884		16
17	Accumulated Depreciation (book methods)	(25,318)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 164,566	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 333,312	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 45,632	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,320		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,783		30
31	Accrued Taxes Payable	139,929		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 238,665	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 238,665	\$	45
46	<b>TOTAL EQUITY</b>	\$ 94,647	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 333,312	\$	47

\*(See instructions.)

Facility Name: The Glenwood of Mt Zion

Report Period Beginning: 1/1/2017

Ending:

12/31/2017

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

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 1,504,322	1
2	Discounts and Allowances	(4,031)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 1,500,291</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services	6,750	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	2,197	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 8,947</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 1,509,238</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	381,892	19
20	Health Care/ Personal Care	271,010	20
21	General Administration	304,306	21
<b>B. Capital Expense</b>			
22	Ownership	436,066	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 1,393,274</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 115,964</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 115,964</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 233,921	32
33	Private Pay - Net Inpatient Revenue	1,266,370	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 1,500,291</b>	<b>37</b>