

		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.

I. Facility ID Number: 1000127

Facility Name: The Glenwood of Mt Zion

Address: 1635 Baltimore Ave Mt Zion 62459

Number City Zip Code

County: Macon

Telephone Number: (217 864-1073 Fax # 217 864-1077

Federal Employer ID Number:

Date Current Owners were Certified: 2014

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: Shellev Welch Telephone Number: (217 821-9539

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 1/1/2017 to 12/31/2017 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)	Shelley Welch	
Paid Preparer	(Title)	Director of Operations	
	(Signed)		(Date)
	(Print Name and Title)		
	(Firm Name & Address)		
	(Telephone)	()	Fax # ()

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

Report Period Beginning: 2017 Ending: 2017

Date of change in certified units

11 / 11

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.

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.)**

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			
	A. General Services					5	6	
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	TOTAL General Services	87,822	155,667	138,402	381,892		381,892	5
	B. Health Care and Programs							
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	TOTAL Health Care and Programs	259,083	1,712	10,215	271,010		271,010	9
	C. General Administration							
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	TOTAL General Administration	142,260	5,391	156,655	304,306		304,306	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	489,166	162,770	305,272	957,208		957,208	16
	Capital Expenses							
	D. Ownership							
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	TOTAL Ownership			436,066	436,066		436,066	23
24	GRAND TOTAL (Sum of lines 16 and 23)	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	Total (lines 1 thru 16)	11	\$	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

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

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? [X] 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*		8. Is movable equipment rental included in building rental? [] YES [X] NO
3	Original Building	2009	38	11/1/2014	\$ 24,999			3	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.
4	Additions			/ /				4	
5				/ /				5	
6				/ /				6	
7	TOTAL		38		\$ 24,999			7	

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					/ /	\$	\$	/ /		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	\$			\$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	\$			\$	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: 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 Operating	2 After Consolidation*	
	A. Current Assets			
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	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 168,746	\$	10
	B. Long-Term Assets			
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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 164,566	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 333,312	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
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
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 238,665	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			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)	\$	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 238,665	\$	45
46	TOTAL EQUITY	\$ 94,647	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 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	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,504,322	1
2	Discounts and Allowances	(4,031)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,500,291	3
	B. Other Operating Revenue		
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	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 8,947	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			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,509,238	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	381,892	19
20	Health Care/ Personal Care	271,010	20
21	General Administration	304,306	21
	B. Capital Expense		
22	Ownership	436,066	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)	\$ 1,393,274	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 115,964	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 115,964	31
	III. Net Resident Care Revenue detailed by Payer Source		
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	TOTAL (This total must agree to Line 3)	\$ 1,500,291	37