

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2006  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2006)**

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.</b></p> <p>Facility Name: <u>The Glenwood</u></p> <p>Address: <u>605 S. Dewey</u> <u>Greenville</u> <u>62246</u>  <small>Number City Zip Code</small></p> <p>County: <u>Bond</u></p> <p>Telephone Number: ( <u>618</u> ) <u>664-9012</u> Fax # <u>618 664-9057</u></p> <p>Federal Employer ID Number: <u>33-1092690</u></p> <p>Date Current Owners were Certified: <u>2002</u></p> <p>Type of Ownership:</p> <table border="0"> <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>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" 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>Shelley Nuelle</u> Telephone Number: ( <u>-9539</u> ) _____</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	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input 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 _____ to _____ 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: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Brad Voyles</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>President</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>Brad Voyles</u> (Date) _____		(Title) <u>President</u>	<b>Paid Preparer</b>	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) ( <u>    </u> ) _____ Fax # ( <u>    </u> ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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	(Telephone) ( <u>    </u> ) _____ Fax # ( <u>    </u> ) _____																																		

Facility Name The Glenwood

Report Period Beginning: 2/22/2006

Ending: 12/31/2006

**III. STATISTICAL DATA**

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

Date of change in certified units 11/29/2006

	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	38	Double Unit Apartment	46	11,894	2
3		Other		256	3
4	38	TOTALS	46	12,150	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	1,976	8,291		10,267	6
7	Other					7
8	TOTALS	1,976	8,291		10,267	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 84.50%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 27 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)

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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: 2006 Fiscal Year: 2006

\* All facilities other than governmental must report on the accrual basis.

**J. Does the facility have any Illinois Housing Development Authority Loans outstanding?** \_\_\_\_\_ 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?** \_\_\_\_\_ 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?** \_\_\_\_\_ If yes, did the facility make all of the required payments of interest and principle? \_\_\_\_\_  
If no, explain. \_\_\_\_\_

Facility Name: The Glenwood

Report Period Beginning:

2/22/2006

Ending:

12/31/2006

## 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	39,449	66,134		105,582		105,582	1
2	Housekeeping, Laundry and Maintenance	16,523	39,236		55,758		55,758	2
3	Heat and Other Utilities			46,037	46,037		46,037	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	55,971	105,369	46,037	207,378		207,378	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	94,866		9,657	104,524		104,524	6
7	Activities and Social Services		2,515		2,515		2,515	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	94,866	2,515	9,657	107,039		107,039	9
<b>C. General Administration</b>								
10	Administrative and Clerical	82,864	14,756		97,619		97,619	10
11	Marketing Materials, Promotions and Advertising		12,658		12,658		12,658	11
12	Employee Benefits and Payroll Taxes	19,879			19,879		19,879	12
13	Insurance-Property, Liability and Malpractice			26,250	26,250		26,250	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	102,743	27,413	26,250	156,405		156,405	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	253,580	135,298	81,944	470,822		470,822	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation							17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			184,000	184,000		184,000	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			184,000	184,000		184,000	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	253,580	135,298	265,944	654,822		654,822	24

Facility Name: The Glenwood

Report Period Beginning 2/22/2006 Ending: 12/31/2006

**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			2
3	Certified Nurse Assistants	7	7.75	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	9.00	6
7	Cook Helpers/Assistants	3	7.33	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	2	7.25	10
11	Laundry			11
12	Managers	1	14.79	12
13	Other Administrative	1	9.00	13
14	Clerical			14
15	Marketing			15
16	Other (Resident Assistants)	5	6.70	16
17	<b>Total (lines 1 thru 16)</b>	<b>20</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>\$</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 <u>1</u>	City <u>2</u>

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
Linden Grove LLC	Effingham, IL	Facility Rental

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

Report Period Beginning:

2/22/2006

Ending:

12/31/2006

**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

Report Period Beginning: 2/22/2006

Ending: ###

**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: Linden Grove LLC

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	2006	38	5/1/06	\$ 23,000	10	none
4	Additions	2006	8	12/31/06	4,500	10	none
5			/ /				
6			/ /				
7	<b>TOTAL</b>		<b>46</b>		<b>\$ 27,500</b>		

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	
		Related**	NO			Original	Balance				Interest Rate (4 Digits)
	Name of Lender	YES	NO	Purpose of Loan	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
<b>A. Directly Facility Related Long-Term</b>											
1					/ /	\$	\$	/ /		\$	
2					/ /			/ /			
3					/ /			/ /			
<b>Working Capital</b>											
4					/ /			/ /			
5					/ /			/ /			
6					/ /			/ /			
7	<b>TOTAL Facility Related</b>					\$	\$			\$	
<b>B. Non-Facility Related</b>											
8					/ /			/ /			
9					/ /			/ /			
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	\$			\$	

\* 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

Page 7

Facility Name: The Glenwood

Report Period Beginning: 2/22/2006

Ending: 12/31/2006

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of \_\_\_\_\_

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 44,384	\$	1
2	Cash-Patient Deposits	30,098		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )			3
4	Supply Inventory (priced at )			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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 74,482	\$	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			16
17	Accumulated Depreciation (book methods)			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>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 74,482	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,098		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	1,267		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>	\$ 31,365	\$	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>	\$ 31,365	\$	45
46	<b>TOTAL EQUITY</b>	\$ 43,117	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 74,482	\$	47

\*(See instructions.)

Facility Name: The Glenwood

Report Period Beginning: 2/22/2006

Ending:

12/31/2006

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 658,831	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 658,831	3
<b>B. Other Operating Revenue</b>			
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	1,147	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 1,147	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$	14
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	\$	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 659,978	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	207,378	19
20	Health Care/ Personal Care	107,039	20
21	General Administration	156,405	21
<b>B. Capital Expense</b>			
22	Ownership	184,000	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</b> (sum of lines 19 thru 27)	\$ 654,822	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ 5,156	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ 5,156	31

**Page 4, VII Related Organizations**

**Item C**

The only related party transaction is the rent expense. The Glenwood facility is owned by Linden Grove, LLC. Linden Grove, LLC is a related party because they have the same ownership as Emerald Glen Management Corp (who runs The Glenwood facility in this report).

Rent expense charged by Linden Grove, LLC for 2006 was \$184,000 (line 20 on page 3).

Linden Grove, LLC's rental fee is calculated to recover the actual cost of building the facility (no markups) over the life of the asset.