

		FOR BHF USE					

LL2

Supportive Living Facility
2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2007)

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>I.</p> <p>Facility Name: <u>The Glenwood of Greenville</u></p> <p>Address: <u>605 S. Dewey Street</u> <u>Greenville</u> <u>62246</u> <small>Number City Zip Code</small></p> <p>County: <u>Bond</u></p> <p>Telephone Number: (<u>618-664-9012</u> Fax # <u>618-664-9057</u></p> <p>Federal Employer ID Number: <u>20-3000418</u></p> <p>Date Current Owners were Certified: <u>2007</u></p> <p>Type of Ownership:</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>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>217 821-9539</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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/07</u> to <u>12/31/07</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 border="1" style="width:100%"> <tr> <td style="width:50%">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>3/22/2008 (Date)</td> </tr> <tr> <td></td> <td colspan="2">(Type or Print Name <u>Shelley Nuelle</u>)</td> </tr> <tr> <td></td> <td colspan="2">(Title) <u>Director of Operations</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date)</td> </tr> <tr> <td></td> <td colspan="2">(Print Name _____ and Title _____)</td> </tr> <tr> <td></td> <td colspan="2">(Firm Name _____ & Address) _____</td> </tr> <tr> <td></td> <td colspan="2">(Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="center"> 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) _____	3/22/2008 (Date)		(Type or Print Name <u>Shelley Nuelle</u>)			(Title) <u>Director of Operations</u>		Paid Preparer	(Signed) _____	(Date)		(Print Name _____ and Title _____)			(Firm Name _____ & Address) _____			(Telephone) () _____ Fax # () _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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	(Firm Name _____ & Address) _____																																													
	(Telephone) () _____ Fax # () _____																																													

Facility Name The Glenwood

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

III. STATISTICAL DATA

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

Date of change in certified units 9/1/07

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End Report Period	Unit Days During Report Period	
1	41	Single Unit Apartment	49	17,885	1
2	7	Double Unit Apartment	7	2,492	2
3		Other		2,492	3
4	48	TOTALS	56	22,869	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	4,226	13,153		17,379	5
6	Double Unit		2,092		2,092	6
7	Other		2,212		2,212	7
8	TOTALS	4,226	17,457	0	21,683	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 94.81%

D. Indicate the number of paid bed-hold days the SLF had during this year 302 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)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: 2007 Fiscal Year: 2007

* 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. _____

STATE OF ILLINOIS

Page 3

Facility Name: The Glenwood

Report Period Beginning: January 1, 20

Ending: December 31, 2007

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
		1	2	3	4	5	6	
	A. General Services							
1	Dietary and Food Purchase	38,555	99,694		138,249		138,249	1
2	Housekeeping, Laundry and Maintenance	35,891	48,230		84,121		84,121	2
3	Heat and Other Utilities			78,097	78,097		78,097	3
4	Other (specify):				0		0	4
5	TOTAL General Services	74,447	147,924	78,097	300,467	0	300,467	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	182,001		14,454	196,455		196,455	6
7	Activities and Social Services		2,685		2,685		2,685	7
8	Other (specify):				0		0	8
9	TOTAL Health Care and Programs	182,001	2,685	14,454	199,140	0	199,140	9
	C. General Administration							
10	Administrative and Clerical	50,161	3,627		53,788		53,788	10
11	Marketing Materials, Promotions and Advertising		4,719		4,719		4,719	11
12	Employee Benefits and Payroll Tax	34,747			34,747		34,747	12
13	Insurance-Property, Liability and Malpractice			28,511	28,511		28,511	13
14	Other (specify):				0		0	14
15	TOTAL General Administration	84,908	8,346	28,511	121,765	0	121,765	15
16	(Sum of lines 5, 9 and 15)	341,356	158,955	121,061	621,372	0	621,372	16
	Capital Expenses							
	D. Ownership							
17	Depreciation				0		0	17
18	Interest				0		0	18
19	Real Estate Taxes				0		0	19
20	Rent -- Facility and Grounds			334,600	334,600		334,600	20
21	Rent -- Equipment				0		0	21
22	Other (specify):				0		0	22
23	TOTAL Ownership	0	0	334,600	334,600	0	334,600	23
24	GRAND TOTAL (Sum of lines 16 and 23)	341,356	158,955	455,661	955,972	0	955,972	24

Facility Name: **The Glenwood**

Report Period Beginning: **January 1, 20** Ending: **December 31, 2007**

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	8	8.75	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	8.75	6
7	Cook Helpers/Assistants	1	8.00	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	3	8.00	10
11	Laundry			11
12	Managers	1	14.93	12
13	Other Administrative	1	8.50	13
14	Clerical			14
15	Marketing			15
16	Other (Resident Assistants)	11	7.75	16
17	Total (lines 1 thru 16)	26	\$	17

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				\$ 0	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
Total		\$ 0 3

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 Busin	5
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:

January 1, 2007

Ending:

December 31, 2007

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					\$	\$		\$	0	\$	1
2									0		2
3									0		3
4									0		4
5									0		5
	Improvement Type										
6									0		6
7									0		7
8									0		8
9									0		9
10									0		10
11									0		11
12									0		12
13									0		13
14									0		14
15									0		15
16									0		16
17	TOTAL (lines 1 thru 16)				\$ 0	\$ 0		\$ 0	\$ 0	\$ 0	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)	\$ 0	\$ 0	\$ 0	\$		\$	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: January 1, 20 Ending: December 31, 2007

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	3
4	Additions	2006	8	12/31/06	4,500	10	none	4
5		2007	10	12/1/07	4,600	10	none	5
6				/ /				6
7	TOTAL		56		\$ 32,100			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
			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					\$	0	\$ 0			\$	0
B. Non-Facility Related												
8					/ /				/ /			8
9					/ /				/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	0	\$ 0			\$	0

* 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

Report Penuary 1, 2007

Ending:

December 31, 2007

December 31, 2007

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of

December 31, 2007

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 30,036	\$	1
2	Cash-Patient Deposits	35,837		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	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 65,873	\$ 0	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			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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 0	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 65,873	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,837		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	0		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)	\$ 35,837	\$ 0	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)	\$ 0	\$ 0	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 35,837	\$ 0	45
46	TOTAL EQUITY	\$ 30,036	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 65,873	\$ 0	47

*(See instructions.)

Facility Name: The Glenwood

Report Period Beginning: January 1, 2007 Ending: December 31, 2007

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

		1	
		Revenue	Amount
A. SLF Resident Care			
1	Gross SLF Resident R	\$ 1,350,426	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,350,426	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	941	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 941	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)	\$ 0	14
D. Other Revenue (specify):			
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 0	17
18	TOTAL REVENUE (sum of lines 3, 11, 14)	\$ 1,351,367	18

		2	
		Expenses	Amount
A. Operating Expenses			
19	General Services	300,467	19
20	Health Care/ Personal Care	199,140	20
21	General Administration	121,765	21
B. Capital Expense			
22	Ownership	334,600	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)	\$ 955,972	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 395,395	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 395,395	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 2007 was \$334,600 (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.