

		FOR BHF USE			

LL2

Supportive Living Facility

**2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2013)**

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. Facility ID Number: <u>1000127</u></p> <p>Facility Name: <u>The Glenwood of Mt Zion</u></p> <p>Address: <u>1635 Baltimore Ave</u> <u>Mt Zion</u> <u>62549</u> <small>Number City Zip Code</small></p> <p>County: <u>Macon</u></p> <p>Telephone Number: (<u>217</u>) <u>864-1073</u> Fax # <u>217 864-1077</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>2011</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>Shellev Nuelle</u> Telephone Number: (<u>217</u>) <u>821-9539</u> Email Address: _____</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>1/01/13</u> to <u>12/31/13</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) _____ (Type or Print Name) <u>Shelley Nuelle</u> (Title) <u>Director</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </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) _____ (Type or Print Name) <u>Shelley Nuelle</u> (Title) <u>Director</u>	Paid Preparer	(Signed) _____ (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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Facility Name: The Glenwood of Mt Zion

Report Period Beginning:

1/01/13

Ending:

12/31/13

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	42,994	104,074		147,067		147,067	1
2	Housekeeping, Laundry and Maintenance	34,977	64,964		99,941		99,941	2
3	Heat and Other Utilities			88,867	88,867		88,867	3
4	Other (specify):							4
5	TOTAL General Services	77,971	169,038	88,867	335,875		335,875	5
B. Health Care and Programs								
6	Health Care/ Personal Care	295,107	2,129		297,236		297,236	6
7	Activities and Social Services		4,630		4,630		4,630	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	295,107	6,758		301,865		301,865	9
C. General Administration								
10	Administrative and Clerical	42,637	4,708		47,345		47,345	10
11	Marketing Materials, Promotions and Advertising		36,218		36,218		36,218	11
12	Employee Benefits and Payroll Taxes	39,956	3,116		43,072		43,072	12
13	Insurance-Property, Liability and Malpractice			29,268	29,268		29,268	13
14	Other (specify):							14
15	TOTAL General Administration	82,592	44,042	29,268	155,903		155,903	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	455,670	219,838	118,135	793,643		793,643	16
Capital Expenses								
D. Ownership								
17	Depreciation							17
18	Interest							18
19	Real Estate Taxes			57,990	57,990		57,990	19
20	Rent -- Facility and Grounds			306,000	306,000		306,000	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			363,990	363,990		363,990	23
24	GRAND TOTAL (Sum of lines 16 and 23)	455,670	219,838	482,125	1,157,633		1,157,633	24

Facility Name: The Glenwood of Mt Zion

Report Period Beginning 1/01/13

Ending: 12/31/13

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	20.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	5	10.25	3
4	Activity Director & Assistants			4
5	Social Service Workers	1		5
6	Head Cook	2	11.00	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers	1	10.00	9
10	Housekeepers			10
11	Laundry	1	10.00	11
12	Managers	1	20.40	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other	5	9.75	16
17	Total (lines 1 thru 16)	17	\$	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	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
		Total
		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 Business	5
Baltimore Development		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).

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Report Period Beginning:

1/01/13

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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: 1/01/13

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IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Baltimore Development 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	2009	38	11/1/09	\$ 25,500	10	None	3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		38		\$ 25,500			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		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related									
	Long-Term									
1					/ /	\$	\$	/ /		\$
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$	\$			\$
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$	\$			\$

* 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.

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Ending:

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 97,789	\$	1
2	Cash-Patient Deposits	27,500		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)	\$ 125,289	\$	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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 125,289	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,500		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			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)	\$ 27,500	\$	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)	\$ 27,500	\$	45
46	TOTAL EQUITY	\$ 97,789	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 125,289	\$	47

*(See instructions.)

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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 Revenue	\$ 1,358,270	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,358,270	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	1,448	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 1,448	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)	\$ 1,359,718	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	335,875	19
20	Health Care/ Personal Care	301,865	20
21	General Administration	155,903	21
B. Capital Expense			
22	Ownership	363,990	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)	\$ 1,157,633	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 202,085	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 202,085	31

