

		FOR BHF USE			

LL2

Supportive Living Facility
2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)

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>1000058</u></p> <p>Facility Name: <u>The Glenwood of Greenville</u></p> <hr/> <p>Address: <u>605 S Dewey Street</u> <u>Greenville</u> <u>62246</u></p> <p align="center">Number City Zip Code</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: _____</p> <p>Date Current Owners were Certified: <u>2014</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. Trust Other</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL State County Other</td> </tr> </table> <p>IRS Exemption Code _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.	<input type="checkbox"/> PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. Trust Other	<input type="checkbox"/> GOVERNMENTAL State County 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>1/01/18</u> to <u>12/31/18</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 align="center">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%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>Michelle Sowell</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>Director of Operations</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>Shelley Welch</u> (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) (_____) Fax # (_____)</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Michelle Sowell</u>		(Title) <u>Director of Operations</u>	Paid Preparer	(Signed) <u>Shelley Welch</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (_____) Fax # (_____)
<input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.	<input type="checkbox"/> PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. Trust Other	<input type="checkbox"/> GOVERNMENTAL State County Other																
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	(Print Name and Title) _____																	
	(Firm Name & Address) _____																	
	(Telephone) (_____) Fax # (_____)																	
<p>In the event there are further questions about this report, please contact:</p> <p>Name: <u>Michelle Sowell</u> Telephone Number: (<u>217-821-8508</u>)</p> <p>Email Address: _____</p>	<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>																	

Facility Name The Glenwood of Greenville

Report Period Beginning: 1/01/18 Ending: 12/31/18

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	49	Single Unit Apartment	49	17,885	1
2	7	Double Unit Apartment	7	2,555	2
3		Other			3
4	56	TOTALS	56	20,440	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	5,159	10,891		16,050	5
6	Double Unit	730	1,642		2,372	6
7	Other					7
8	TOTALS	5,889	12,533		18,422	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.13%

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

34 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 8 (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: 2018 Fiscal Year: 2018

* 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 principal? _____
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 principal? _____
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 principal? _____
If no, explain. _____

Facility Name: The Glenwood of Greenville

Report Period Beginning:

1/01/18

Ending:

12/31/18

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	84,826	148,409		233,234		233,234	1
2	Housekeeping, Laundry and Maintenance	43,217	68,309		111,526		111,526	2
3	Heat and Other Utilities			88,796	88,796		88,796	3
4	Other (specify): Fire Inspection Testing			3,526	3,526		3,526	4
5	TOTAL General Services	128,043	216,717	92,321	437,082		437,082	5
B. Health Care and Programs								
6	Health Care/ Personal Care	282,054	671	14,922	297,648		297,648	6
7	Activities and Social Services			7,911	7,911		7,911	7
8	Other (specify): Training & Education			967	967		967	8
9	TOTAL Health Care and Programs	282,054	671	23,800	306,526		306,526	9
C. General Administration								
10	Administrative and Clerical	63,857	2,622	121,466	187,945		187,945	10
11	Marketing Materials, Promotions and Advertising		4,038	15,902	19,939		19,939	11
12	Employee Benefits and Payroll Taxes	61,406			61,406		61,406	12
13	Insurance-Property, Liability and Malpractice			29,625	29,625		29,625	13
14	Other (specify): Auto Fuel/Mnt Exp & Bad Debt			109,687	109,687		109,687	14
15	TOTAL General Administration	125,263	6,660	276,680	408,603		408,603	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	535,360	224,048	392,801	1,152,210		1,152,210	16
Capital Expenses								
D. Ownership								
17	Depreciation			20,102	20,102		20,102	17
18	Interest							18
19	Real Estate Taxes			94,349	94,349		94,349	19
20	Rent -- Facility and Grounds			725,972	725,972		725,972	20
21	Rent -- Equipment							21
22	Other (specify): Minor Furniture & Fixtures		1,458		1,458		1,458	22
23	TOTAL Ownership		1,458	840,424	841,881		841,881	23
24	GRAND TOTAL (Sum of lines 16 and 23)	535,360	225,506	1,233,225	1,994,091		1,994,091	24

Facility Name: The Glenwood of Greenville

Report Period Beginning: 1/01/18 Ending: 12/31/18

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 22.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	3	10.40	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	12.00	6
7	Cook Helpers/Assistants	2	10.75	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	9.95	10
11	Laundry			11
12	Managers	1	17.05	12
13	Other Administrative	1	13.39	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	10	\$	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
GAHCR II Greenville 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 Greenville

Report Period Beginning:

1/01/18

Ending:

12/31/18

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 Greenville

Report Period Beginning: 1/01/18

Ending: 12/31/18

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Colony 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	2006	38	11/1/2014	\$ 60,748	5	None	3
4	Additions	2006	8	/ /				4
5		2007	10	/ /				5
6				/ /				6
7	TOTAL		56		\$ 60,748			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**	YES			NO	Amount of Note				
					Purpose of Loan	Date of Note	Original		Maturity Date			
		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.

Facility Name: The Glenwood of Greenville

Report Period Beginning: 1/01/18

Ending:

12/31/18

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 88,529	\$	1
2	Cash-Patient Deposits	36,865		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	151,070		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,274		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)	\$ 291,738	\$	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	352,847		16
17	Accumulated Depreciation (book methods)	(57,907)		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)	\$ 294,940	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 586,678	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 33,785	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,865		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,531		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)	\$ 195,181	\$	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)	\$ 195,181	\$	45
46	TOTAL EQUITY	\$ 391,497	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 586,678	\$	47

*(See instructions.)

Facility Name: The Glenwood of Greenville

Report Period Beginning: 1/01/18

Ending:

12/31/18

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	\$ 2,012,505	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,012,505	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	2,122	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 8,872	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)	\$ 2,021,377	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	437,082	19
20	Health Care/ Personal Care	306,526	20
21	General Administration	408,603	21
B. Capital Expense			
22	Ownership	841,881	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)	\$ 1,994,091	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 27,286	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 27,286	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 358,614	32
33	Private Pay - Net Inpatient Revenue	1,653,891	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,012,505	37