

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><b>I. Facility ID Number:</b> <u>1000079</u></p> <p><b>Facility Name:</b> <u>The Glenwood of Staunton</u></p> <hr/> <p><b>Address:</b> <u>18192 Renken Road</u> <u>Staunton</u> <u>62088</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>Macoupin</u></p> <p><b>Telephone Number:</b> ( <u>618</u> ) <u>635-4012</u> Fax # <u>618 635-4412</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>2014</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input checked="" 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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Michelle Sowell</u> <b>Telephone Number:</b> ( <u>217-821-8508</u> )  <b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input checked="" 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 <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%"> <tr> <td rowspan="2" style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td align="right">(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Michelle Sowell</u></td> </tr> <tr> <td></td> <td>(Title) <u>Director of Operations</u></td> </tr> <tr> <td rowspan="4" style="width:20%;"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td align="right">(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <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) _____	(Date) _____		(Type or Print Name) <u>Michelle Sowell</u>		(Title) <u>Director of Operations</u>	<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) ( <u>    </u> ) _____ Fax # ( <u>    </u> ) _____
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Facility Name The Glenwood of Staunton

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	59	Single Unit Apartment	59	21,535	1
2	3	Double Unit Apartment	3	1,095	2
3		Other			3
4	62	TOTALS	62	22,630	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	5,194	16,597		21,791	5
6	Double Unit		791		791	6
7	Other					7
8	TOTALS	5,194	17,388		22,582	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.79%

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

91 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 98 (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: 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 Staunton

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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	67,204	159,663	7,751	234,618		234,618	1
2	Housekeeping, Laundry and Maintenance	40,526	67,362		107,888		107,888	2
3	Heat and Other Utilities			131,845	131,845		131,845	3
4	Other (specify): Fire Inspection Testing			2,375	2,375		2,375	4
5	<b>TOTAL General Services</b>	<b>107,730</b>	<b>227,025</b>	<b>141,971</b>	<b>476,725</b>		<b>476,725</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	287,888	637	3,497	292,022		292,022	6
7	Activities and Social Services			6,760	6,760		6,760	7
8	Other (specify): Training & Education			1,115	1,115		1,115	8
9	<b>TOTAL Health Care and Programs</b>	<b>287,888</b>	<b>637</b>	<b>11,372</b>	<b>299,897</b>		<b>299,897</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	72,015	2,759	178,796	253,571		253,571	10
11	Marketing Materials, Promotions and Advertising		2,993	24,498	27,490		27,490	11
12	Employee Benefits and Payroll Taxes	73,390			73,390		73,390	12
13	Insurance-Property, Liability and Malpractice			34,681	34,681		34,681	13
14	Other (specify): Auto Fuel/Mnt Exp & Bad Debt			50,119	50,119		50,119	14
15	<b>TOTAL General Administration</b>	<b>145,405</b>	<b>5,752</b>	<b>288,093</b>	<b>439,251</b>		<b>439,251</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>541,023</b>	<b>233,414</b>	<b>441,437</b>	<b>1,215,873</b>		<b>1,215,873</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			21,291	21,291		21,291	17
18	Interest							18
19	Real Estate Taxes			86,403	86,403		86,403	19
20	Rent -- Facility and Grounds			609,663	609,663		609,663	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>717,358</b>	<b>717,358</b>		<b>717,358</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>541,023</b>	<b>233,414</b>	<b>1,158,794</b>	<b>1,933,230</b>		<b>1,933,230</b>	<b>24</b>

Facility Name: The Glenwood of Staunton

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	\$ 24.20	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	4	10.45	3
4	Activity Director & Assistants	1	11.85	4
5	Social Service Workers			5
6	Head Cook	1	11.85	6
7	Cook Helpers/Assistants	2	9.70	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	9.35	10
11	Laundry			11
12	Managers	1	20.66	12
13	Other Administrative	1	13.69	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>12</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>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>3</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	1	City	2

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
GAHCR II Staunton ALF TRS Sub LLC					
Senior Health Specialties, Inc					

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 Staunton

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
	<b>Improvement Type</b>										
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 Staunton

Report Period Beginning: 1/01/18

Ending: 12/31/18

**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  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*	
3	Original Building	2007	38	11/1/2014	\$ 49,566	5	None	3
4	Additions	2008	16	/ /		5	None	4
5		2009	8	/ /		5	None	5
6				/ /				6
7	<b>TOTAL</b>		62		\$ 49,566			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 Related**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1					/ /	\$	\$	/ /		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
	<b>Working Capital</b>										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$	\$			\$	7
	<b>B. Non-Facility Related</b>										
8					/ /			/ /			8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	\$			\$	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 Staunton

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 70,867	\$	1
2	Cash-Patient Deposits	55,277		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	129,448		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,017		6
7	Other Prepaid Expenses	15,000		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>	\$ 311,609	\$	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	341,623		16
17	Accumulated Depreciation (book methods)	(63,109)		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>	\$ 278,514	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 590,123	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 48,025	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,277		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,547		30
31	Accrued Taxes Payable	98,233		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>	\$ 220,082	\$	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>	\$ 220,082	\$	45
46	<b>TOTAL EQUITY</b>	\$ 370,041	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 590,123	\$	47

\*(See instructions.)

Facility Name: The Glenwood of Staunton

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	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 2,297,022	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 2,297,022</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services	13,500	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	1,997	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 15,497</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 2,312,520</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	476,725	19
20	Health Care/ Personal Care	299,897	20
21	General Administration	439,251	21
<b>B. Capital Expense</b>			
22	Ownership	717,358	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 (sum of lines 19 thru 27)</b>	<b>\$ 1,933,230</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 379,289</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 379,289</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 303,406	32
33	Private Pay - Net Inpatient Revenue	1,993,616	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 2,297,022</b>	<b>37</b>