

		FOR BHF USE			

LL2

Supportive Living Facility

2015

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2015)

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.

I. Facility ID Number: 1000058

Facility Name: The Glenwood of Greenville

Address: 605 S Dewey Street Greenville 62246

Number City Zip Code

County: Bond

Telephone Number: (618) 664-9012 Fax # 618 664-9057

Federal Employer ID Number:

Date Current Owners were Certified: 2014

Type of Ownership:

<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 type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input checked="" type="checkbox"/>	Other	REIT	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from Jan 1, 2015 to Dec. 31, 2015 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____

(Type or Print Name) Shelley Welch

(Title) Director of Operations

Paid
Preparer

(Signed) _____ (Date) _____

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) () Fax # ()

In the event there are further questions about this report, please contact:

Name: Shellev Welch Telephone Number: (217) 821-9539

Email Address: _____

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

Facility Name	The Glenwood of Greenville
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Report Period Beginning: Jan 1, 2015 Ending: Dec. 31,2015

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	5,096	12,032		17,128	5
6	Double Unit		2,330		2,330	6
7	Other					7
8	TOTALS	5,096	14,362		19,458	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 95.20%

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

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)**

H. ACCOUNTING BASIS

ACCUAL	<input type="text" value="x"/>	MODIFIED		
CASH*	<input type="text"/>	CASH*	<input type="text"/>	

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

Tax Year: 2015 **Fiscal Year:** 2015

* 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

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Facility Name: The Glenwood of Greenville

Report Period Beginning:

Jan 1, 2015

Ending: Dec. 31, 2015

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	84,506	146,399		230,906		230,906	1
2	Housekeeping, Laundry and Maintenance	45,478	49,822	400	95,701		95,701	2
3	Heat and Other Utilities			82,017	82,017		82,017	3
4	Other (specify): Fire Inspection Testing			1,507	1,507		1,507	4
5	TOTAL General Services	129,984	196,222	83,925	410,131		410,131	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	273,274	6,129	9,398	288,801		288,801	6
7	Activities and Social Services		1,736	7,613	9,349		9,349	7
8	Other (specify): Training & Education			922	922		922	8
9	TOTAL Health Care and Programs	273,274	7,865	17,932	299,071		299,071	9
	C. General Administration							
10	Administrative and Clerical	58,730	3,160	121,903	183,793		183,793	10
11	Marketing Materials, Promotions and Advertising		1,219	15,311	16,531		16,531	11
12	Employee Benefits and Payroll Taxes	81,177		5,442	86,620		86,620	12
13	Insurance-Property, Liability and Malpractice			30,926	30,926		30,926	13
14	Other (specify): Auto Fuel/Mnt Exp			2,173	2,173		2,173	14
15	TOTAL General Administration	139,907	4,379	175,756	320,042		320,042	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	543,165	208,467	277,613	1,029,244		1,029,244	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			30,820	30,820		30,820	17
18	Interest							18
19	Real Estate Taxes			81,751	81,751		81,751	19
20	Rent -- Facility and Grounds			674,137	674,137		674,137	20
21	Rent -- Equipment							21
22	Other (specify): Minor Furniture & Fixtures		1,612		1,612		1,612	22
23	TOTAL Ownership		1,612	786,708	788,320		788,320	23
24	GRAND TOTAL (Sum of lines 16 and 23)	543,165	210,078	1,064,321	1,817,565		1,817,565	24

Facility Name: The Glenwood of Greenville

Report Period Beginning Jan 1, 2015 Ending: Dec. 31,2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 22.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	3	9.25	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	2	11.20	6
7	Cook Helpers/Assistants	1	9.70	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	9.25	10
11	Laundry			11
12	Managers	1	16.07	12
13	Other Administrative	1	12.05	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	11	\$	17

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).

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

Facility Name: The Glenwood of Greenville

Report Period Beginning:

Jan 1, 2015

Ending:

Dec. 31,2015

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

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IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Northstar

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

X 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	2006	38	5/1/06	\$ 23,000	10	None	3
4	Additions	2006	8	12/31/06	4,000	10	None	4
5		2007	10	12/1/07	4,200	10	None	5
6				/ /				6
7	TOTAL		56		\$ 31,200			7

8. Is movable equipment rental included in building rental?

YES

X 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					/ /	\$	\$	/ /		\$	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.

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Facility Name: The Glenwood of Greenville

Report Period Beginning: Jan 1, 2015

Ending:

Dec. 31,2015

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of Dec. 31,2015

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 139,591	\$	1
2	Cash-Patient Deposits	56,082		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	51,073		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,409		6
7	Other Prepaid Expenses	6,475		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 273,630	\$	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	284,438		16
17	Accumulated Depreciation (book methods)	(30,820)		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): Goodwill	498,000		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 751,618	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,025,248	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 38,438	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,082		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,523		30
31	Accrued Taxes Payable	100,119		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)	\$ 215,162	\$	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)	\$ 215,162	\$	45
46	TOTAL EQUITY	\$	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 215,162	\$	47

*(See instructions.)

Facility Name: The Glenwood of Greenville

Report Period Beginning: Jan 1, 2015 Ending: Dec. 31, 2015

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

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,917,433	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,917,433	3
	B. Other Operating Revenue		
4	Special Services	210	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	3,476	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 3,686	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)	\$ 1,921,119	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	410,131	19
20	Health Care/ Personal Care	299,071	20
21	General Administration	320,042	21
	B. Capital Expense		
22	Ownership	788,320	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)	\$ 1,817,565	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 103,555	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 103,555	31