

		FOR BHF USE			

LL2

Supportive Living Facility

2017

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2017)

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:

☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☐	Corporation	☐	Other
		☒	"Sub-S" Corp.		
		☒	Limited Liability Co.		
		☐	Trust		
		☐	Other		

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

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

Email Address:

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 2017 to Dec 2017 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	
Paid Preparer	(Title)	Director of Operations	
	(Signed)		(Date)
	(Print Name and Title)		
	(Firm Name & Address)		
	(Telephone)	()	Fax # ()

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

Report Period Beginning: Jan 2017 Ending: Dec 2017

Date of change in certified units

11 / 11

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.

1 Also, indicate the number of unpaid bed-hold days the SLF had during this year. **3 (Do not include bed-hold days in Section B.)**

STATE OF ILLINOIS

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Facility Name: The Glenwood of Greenville

Report Period Beginning:

Jan 2017

Ending:

Dec 2017

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	86,333	144,996		231,329		231,329	1
2	Housekeeping, Laundry and Maintenance	41,990	67,052		109,041		109,041	2
3	Heat and Other Utilities			92,495	92,495		92,495	3
4	Other (specify): Fire Inspection Testing			1,737	1,737		1,737	4
5	TOTAL General Services	128,323	212,048	94,231	434,602		434,602	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	274,957	657	12,698	288,312		288,312	6
7	Activities and Social Services			6,713	6,713		6,713	7
8	Other (specify): Training & Education			1,477	1,477		1,477	8
9	TOTAL Health Care and Programs	274,957	657	20,889	296,503		296,503	9
	C. General Administration							
10	Administrative and Clerical	62,298	3,325	136,296	201,919		201,919	10
11	Marketing Materials, Promotions and Advertising		1,802	15,681	17,482		17,482	11
12	Employee Benefits and Payroll Taxes	60,246			60,246		60,246	12
13	Insurance-Property, Liability and Malpractice			29,492	29,492		29,492	13
14	Other (specify): Auto Fuel/Mnt Exp & Bad Debt			15,346	15,346		15,346	14
15	TOTAL General Administration	122,544	5,126	196,815	324,485		324,485	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	525,824	217,831	311,935	1,055,590		1,055,590	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			37,805	37,805		37,805	17
18	Interest							18
19	Real Estate Taxes			100,186	100,186		100,186	19
20	Rent -- Facility and Grounds			708,266	708,266		708,266	20
21	Rent -- Equipment							21
22	Other (specify): Minor Furniture & Fixtures		4,059		4,059		4,059	22
23	TOTAL Ownership		4,059	846,256	850,315		850,315	23
24	GRAND TOTAL (Sum of lines 16 and 23)	525,824	221,891	1,158,191	1,905,905		1,905,905	24

Facility Name: The Glenwood of Greenville

Report Period Beginning Jan 2017 Ending: Dec 2017

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 22.50	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	3	9.85	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	2	11.90	6
7	Cook Helpers/Assistants	2	10.60	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	9.85	10
11	Laundry			11
12	Managers	1	16.81	12
13	Other Administrative	1	13.03	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

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

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: Jan 2017 Ending: Dec 2017

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	11/1/2014	\$ 59,022	10	None	3
4	Additions	2006	8				None	4
5		2007	10				None	5
6				/ /				6
7	TOTAL		56		\$ 59,022			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.

STATE OF ILLINOIS

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Facility Name: The Glenwood of Greenville

Report Period Beginning: Jan 2017

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of Dec 2017

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 65,026	\$	1
2	Cash-Patient Deposits	47,045		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	175,760		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,990		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)	\$ 304,821	\$	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	310,591		16
17	Accumulated Depreciation (book methods)	(37,805)		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)	\$ 272,786	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 577,607	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 60,118	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,045		28
29	Short-Term Notes Payable	8,690		29
30	Accrued Salaries Payable	23,330		30
31	Accrued Taxes Payable	104,681		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)	\$ 243,864	\$	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)	\$ 243,864	\$	45
46	TOTAL EQUITY	\$ 333,743	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 577,607	\$	47

*(See instructions.)

Facility Name: The Glenwood of Greenville

Report Period Beginning: Jan 2017

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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	\$ 2,038,959	1
2	Discounts and Allowances		2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 2,038,959	3
	B. Other Operating Revenue		
4	Special Services	14,250	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	2,907	9
10	Laundry		10
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$ 17,157	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$	14
	D. Other Revenue (specify):		
15			15
16			16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 2,056,116	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	434,602	19
20	Health Care/ Personal Care	296,503	20
21	General Administration	324,485	21
	B. Capital Expense		
22	Ownership	850,315	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 1,905,905	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ 150,211	29
30	Income Taxes	\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ 150,211	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 355,018	32
33	Private Pay - Net Inpatient Revenue	1,683,941	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,038,959	37