

		FOR BHF USE			

LL2

Supportive Living Facility

2021

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2021)

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: Glenwood of Greenville

Address: 605 S Dewey Street Greenville 62246

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

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

☒ Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/21 to 12/31/21 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)

(Type or Print Name) Penny Dowell

(Title) Director of Operations

Paid Preparer

(Signed)

(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

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

Name: Penny Dowell

Telephone Number: ( 217-342-4490 Opt 1

Email Address:

HFS 3745C (N-4-05)

IL478-2471

**Report Period Beginning: 1/1/21 Ending: 12/31/21**

### Date of change in certified units

/ /

**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.**

**78** Also, indicate the number of unpaid bed-hold days the SLF had during this year. **2 (Do not include bed-hold days in Section B.)**

## STATE OF ILLINOIS

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Facility Name: Glenwood of Greenville

Report Period Beginning:

1/1/21

Ending:

12/31/21

## 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	83,685	146,004	7,461	237,150		237,150	1
2	Housekeeping, Laundry and Maintenance	50,865	51,431	8,328	110,624		110,624	2
3	Heat and Other Utilities			78,980	78,980		78,980	3
4	Other (specify): Fire Inspection			1,199	1,199		1,199	4
5	<b>TOTAL General Services</b>	134,550	197,434	95,968	427,953		427,953	5
	<b>B. Health Care and Programs</b>							
6	Health Care/ Personal Care	315,000	819	4,631	320,450		320,450	6
7	Activities and Social Services			6,814	6,814		6,814	7
8	Other (specify): Covid Supplies		2,887		2,887		2,887	8
9	<b>TOTAL Health Care and Programs</b>	315,000	3,706	11,445	330,151		330,151	9
	<b>C. General Administration</b>							
10	Administrative and Clerical	78,191	3,195	119,012	200,399		200,399	10
11	Marketing Materials, Promotions and Advertising			20,389	20,389		20,389	11
12	Employee Benefits and Payroll Taxes	58,203		2,974	61,177		61,177	12
13	Insurance-Property, Liability and Malpractice			72,243	72,243		72,243	13
14	Other (specify): Bad Debt			169,577	169,577		169,577	14
15	<b>TOTAL General Administration</b>	136,394	3,195	384,196	523,786		523,786	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	585,944	204,336	491,609	1,281,890		1,281,890	16
	<b>Capital Expenses</b>							
	<b>D. Ownership</b>							
17	Depreciation							17
18	Interest							18
19	Real Estate Taxes			96,405	96,405		96,405	19
20	Rent -- Facility and Grounds			791,502	791,502		791,502	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			887,907	887,907		887,907	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	585,944	204,336	1,379,516	2,169,797		2,169,797	24

Facility Name: Glenwood of Greenville

Report Period Beginning 1/1/21 Ending: 12/31/21

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 25.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	5	12.75	3
4	Activity Director & Assistants	4	11.25	4
5	Social Service Workers			5
6	Head Cook	1	13.50	6
7	Cook Helpers/Assistants	2	11.50	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	11.00	10
11	Laundry	1	11.00	11
12	Managers	1	21.00	12
13	Other Administrative	1	14.50	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	17	\$	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 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).

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

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: Glenwood of Greenville Report Period Beginning: 1/1/21 Ending: 12/31/21

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? X 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	\$ 791,502			3
4	Additions	2006	8	/ /				4
5		2007	10	/ /				5
6				/ /				6
7	TOTAL		56		\$ 791,502			7

8. Is movable equipment rental included in building rental?  
YES NO X

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: Glenwood of Greenville

Report Period Beginning: 1/1/21

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## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/21

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 71,464	\$	1
2	Cash-Patient Deposits	28,794		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	295,199		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,594		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	73,645		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 494,696	\$	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	720,383		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 662,476	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,157,173	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 51,602	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,794		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,871		30
31	Accrued Taxes Payable	101,935		31
32	Accrued Interest Payable			32
33	Due to Other Entities	14,633		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>	\$ 241,835	\$	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>	\$ 241,835	\$	45
46	<b>TOTAL EQUITY</b>	\$ 915,337	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 1,157,173	\$	47

\*(See instructions.)

Facility Name: Glenwood of Greenville

Report Period Beginning: 1/1/21

Ending:

12/31/21

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

		1	
	<b>I. Revenue</b>	<b>Amount</b>	
	<b>A. SLF Resident Care</b>		
1	Gross SLF Resident Revenue	\$ 1,731,324	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	\$ 1,731,324	3
	<b>B. Other Operating Revenue</b>		
4	Special Services	7,000	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	123	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	\$ 7,123	11
	<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>	\$	14
	<b>D. Other Revenue (specify):</b>		
15	CARES Act	73,645	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	\$ 73,645	17
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	\$ 1,812,092	18

		2	
	<b>II. Expenses</b>	<b>Amount</b>	
	<b>A. Operating Expenses</b>		
19	General Services	427,953	19
20	Health Care/ Personal Care	330,151	20
21	General Administration	523,786	21
	<b>B. Capital Expense</b>		
22	Ownership	887,907	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>	\$ 2,169,797	28
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	\$ (357,704)	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	\$ (357,704)	31
	<b>III. Net Resident Care Revenue detailed by Payer Source</b>		
32	Medicaid - Net Inpatient Revenue	\$ 323,042	32
33	Private Pay - Net Inpatient Revenue	1,408,282	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>	\$ 1,731,324	37