

		FOR BHF USE			

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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: 1000079 Facility Name: <u>Glenwood of Staunton</u> Address: <u>18192 Renken Road</u> <u>Staunton</u> <u>62088</u> <div style="display: flex; justify-content: space-around; width: 100%;"> Number City Zip Code </div> County: <u>Macoupin</u> Telephone Number: (<u>618</u>) <u>635-4012</u> Fax # <u>618</u> <u>635-4412</u> Federal Employer ID Number: _____ Date Current Owners were Certified: <u>2014</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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Facility Name Glenwood of StauntonReport Period Beginning: 1/1/21 Ending: 12/31/21

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	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	6,059	13,883		19,942	5
6	Double Unit		963		963	6
7	Other					7
8	TOTALS	6,059	14,846		20,905	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.38%

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

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐I. Is your fiscal year identical to your tax year? ☐ YES ☐ NOTax Year: 2021 Fiscal Year: 2021

* 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 therequired 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 therequired 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 facilitymake all of the required payments of interest and principal? If no, explain.

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1/1/21

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IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	84,449	165,326	7,942	257,717		257,717	1
2	Housekeeping, Laundry and Maintenance	51,666	37,693	23,364	112,722		112,722	2
3	Heat and Other Utilities			136,689	136,689		136,689	3
4	Other (specify): Fire Inspection			1,325	1,325		1,325	4
5	TOTAL General Services	136,114	203,019	169,319	508,453		508,453	5
B. Health Care and Programs								
6	Health Care/ Personal Care	299,422	726	5,111	305,259		305,259	6
7	Activities and Social Services			7,414	7,414		7,414	7
8	Other (specify): Covid Supplies		2,946		2,946		2,946	8
9	TOTAL Health Care and Programs	299,422	3,672	12,525	315,618		315,618	9
C. General Administration								
10	Administrative and Clerical	64,381	2,356	182,450	249,188		249,188	10
11	Marketing Materials, Promotions and Advertising			21,044	21,044		21,044	11
12	Employee Benefits and Payroll Taxes	59,430		2,131	61,561		61,561	12
13	Insurance-Property, Liability and Malpractice			77,531	77,531		77,531	13
14	Other (specify): Bad Debt			226,642	226,642		226,642	14
15	TOTAL General Administration	123,811	2,356	509,798	635,966		635,966	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	559,347	209,047	691,642	1,460,037		1,460,037	16
Capital Expenses								
D. Ownership								
17	Depreciation							17
18	Interest							18
19	Real Estate Taxes			83,098	83,098		83,098	19
20	Rent -- Facility and Grounds			900,922	900,922		900,922	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			984,020	984,020		984,020	23
24	GRAND TOTAL (Sum of lines 16 and 23)	559,347	209,047	1,675,662	2,444,057		2,444,057	24

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 26.50	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	5	12.50	3
4	Activity Director & Assistants	4	11.25	4
5	Social Service Workers			5
6	Head Cook	1	15.00	6
7	Cook Helpers/Assistants	2	11.25	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	11.00	10
11	Laundry	1	11.00	11
12	Managers	1	19.25	12
13	Other Administrative	1	15.00	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 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).

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

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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
6	Improvement Type										
7											6
8											7
9											8
10											9
11											10
12											11
13											12
14											13
15											14
16											15
17	TOTAL (lines 1 thru 16)				\$	\$		\$	\$	\$	16

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 StauntonReport Period Beginning: 1/1/21Ending: 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? ☒ 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	2007	38	11/1/201	\$ 900,922	
4	Additions	2008	16	/ /		
5		2009	8	/ /		
6			/ /			
7	TOTAL		62	\$ 900,922		

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		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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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/21

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 75,418	\$	1
2	Cash-Patient Deposits	50,257		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	321,259		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,476		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Utility Deposit	15,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 489,410	\$	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	537,219		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 474,110	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 963,520	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 58,653	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,257		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,983		30
31	Accrued Taxes Payable	84,000		31
32	Accrued Interest Payable			32
33	Due to Other Entities	583,086		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)	\$ 816,978	\$	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)	\$ 816,978	\$	45
46	TOTAL EQUITY	\$ 146,542	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 963,520	\$	47

*(See instructions.)

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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	\$ 2,342,749	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,342,749	3
	B. Other Operating Revenue		
4	Special Services	14,000	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	46	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 14,046	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	CARES Act	17,395	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 17,395	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,374,191	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	508,453	19
20	Health Care/ Personal Care	315,618	20
21	General Administration	635,966	21
	B. Capital Expense		
22	Ownership	984,020	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)	\$ 2,444,057	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (69,867)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (69,867)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 428,883	32
33	Private Pay - Net Inpatient Revenue	1,913,866	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,342,749	37