

		FOR BHF USE			

LL2

Supportive Living Facility
2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2020)

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: The Glenwood of Staunton

Address: 18192 Renken Road Staunton 62088
 Number City Zip Code

County: Macoupin

Telephone Number: (618) 635-4012 **Fax #** 618 635-4412

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 _____	_____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the
 State of Illinois, for the period from 1/01/2020 to 12/31/2020
 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) _____ 6/29/2021
 (Date)

(Type or Print Name) Michelle Sowell

(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: Michelle Sowell **Telephone Number:** 217-342-4490 X:200
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

Report Period Beginning: 1/01/2020 Ending: 12/31/2020

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.

1,006 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. 47 (Do not include bed-hold days in Section B.)

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Facility Name: The Glenwood of Staunton

Report Period Beginning:

1/01/2020

Ending:

12/31/2020

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	79,928	166,497	7,909	254,334		254,334	1
2	Housekeeping, Laundry and Maintenance	44,493	58,212	10,155	112,861		112,861	2
3	Heat and Other Utilities			129,408	129,408		129,408	3
4	Other (specify):							4
5	TOTAL General Services	124,421	224,709	147,472	496,602		496,602	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	300,032	1,351	4,677	306,061		306,061	6
7	Activities and Social Services			3,801	3,801		3,801	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	300,032	1,351	8,478	309,861		309,861	9
	C. General Administration							
10	Administrative and Clerical	76,933	2,641	150,390	229,963		229,963	10
11	Marketing Materials, Promotions and Advertising			27,208	27,208		27,208	11
12	Employee Benefits and Payroll Taxes	62,398		4,189	66,587		66,587	12
13	Insurance-Property, Liability and Malpractice			58,969	58,969		58,969	13
14	Other (specify):			220,308	220,308		220,308	14
15	TOTAL General Administration	139,331	2,641	461,064	603,036		603,036	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	563,785	228,701	617,014	1,409,499		1,409,499	16
	Capital Expenses							
	D. Ownership							
17	Depreciation							17
18	Interest							18
19	Real Estate Taxes			82,760	82,760		82,760	19
20	Rent -- Facility and Grounds			887,610	887,610		887,610	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			970,370	970,370		970,370	23
24	GRAND TOTAL (Sum of lines 16 and 23)	563,785	228,701	1,587,383	2,379,869		2,379,869	24

Facility Name: The Glenwood of Staunton

Report Period Beginning: 1/01/2020 Ending: 12/31/2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 25.85	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	4	11.25	3
4	Activity Director & Assistants	4	10.25	4
5	Social Service Workers			5
6	Head Cook	1	12.00	6
7	Cook Helpers/Assistants	2	10.50	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	10.00	10
11	Laundry			11
12	Managers	1	20.95	12
13	Other Administrative	1	15.19	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	15	\$	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

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: 1/01/2020 Ending: 12/31/2020

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

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	\$ 887,610	5	None	3
4	Additions	2008	16	/ /				4
5		2009	8	/ /				5
6				/ /				6
7	TOTAL		62		\$ 887,610			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	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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Report Period Beginning: 1/01/2020

Ending: 12/31/2020

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 66,263	\$	1
2	Cash-Patient Deposits	51,103		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	294,332		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,999		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)	\$ 451,697	\$	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	483,738		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)	\$ 420,629	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 872,326	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 49,979	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,103		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,394		30
31	Accrued Taxes Payable	85,558		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)	\$ 231,033	\$	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)	\$ 231,033	\$	45
46	TOTAL EQUITY	\$ 641,293	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 872,326	\$	47

*(See instructions.)

Facility Name: The Glenwood of Staunton

Report Period Beginning: 1/01/2020

Ending:

12/31/2020

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	\$ 2,340,222	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,340,222	3
	B. Other Operating Revenue		
4	Special Services	17,000	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	144	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 17,144	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)	\$ 2,357,365	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	496,602	19
20	Health Care/ Personal Care	309,861	20
21	General Administration	603,036	21
	B. Capital Expense		
22	Ownership	970,370	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)	\$ 2,379,869	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (22,504)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (22,504)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 361,621	32
33	Private Pay - Net Inpatient Revenue	1,978,601	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,340,222	37