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: 1000058

Facility Name: The Glenwood of Greenville

Address: 605 S Dewey Street (Number) Greenville (City) 62246 (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.	
	[X] 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 Jan 2020 to Dec 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 # ( )

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: Michelle Sowell **Telephone Number:** 217-342-4490 X:200
Email Address: mlsowell10@gmail.com

Facility Name: The Glenwood of Greenville
Report Period Beginning: Jan 2020 Ending: Dec 2020

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

Facility ID Number: 1000058

	1	2	3	4	
	Units at Report Period		Report Period	Unit Days During Report Period	
1	49	Single Unit Apartment	49	17,934	1
2	7	Double Unit Apartment	7	2,562	2
3		Other			3
4	56	TOTALS	56	20,496	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	5,005	9,756		14,761	5
6	Double Unit	792	1,340		2,132	6
7	Other					7
8	TOTALS	5,797	11,096		16,893	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 82.42%

D. Indicate the number of paid bed-hold days the SLF had during this year 614 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 235 (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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

G. List all services provided by your facility for non-residents.
(E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [ ] YES [ ] NO

Tax Year: 2020 Fiscal Year: 2020

* 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 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 the required 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 facility make all of the required payments of interest and principal? ______
If no, explain.

Facility Name: The Glenwood of Greenville | Report Period Beginning: Jan 2020 | Ending: Dec 2020

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclassifications and Adjustments 5	Adjusted Total 6	
	A. General Services							
1	Dietary and Food Purchase	46,607	175,006	9,693	231,305		231,305	1
2	Housekeeping, Laundry and Maintenance	37,689	66,381	6,837	110,908		110,908	2
	ID Number:				1000058			3
4	Other (specify):							4
5	**TOTAL General Services**	84,296	241,387	16,530	342,213		342,213	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	348,061	1,307	4,239	353,607		353,607	6
7	Activities and Social Services			4,289	4,289		4,289	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	348,061	1,307	8,528	357,896		357,896	9
	C. General Administration							
10	Administrative and Clerical	71,123	2,931	135,022	209,075		209,075	10
11	Marketing Materials, Promotions and Advertising			28,145	28,145		28,145	11
12	Employee Benefits and Payroll Taxes	58,680		4,330	63,010		63,010	12
13	Insurance-Property, Liability and Malpractice			55,519	55,519		55,519	13
14	Other (specify):			260,229	260,229		260,229	14
15	**TOTAL General Administration**	129,803	2,931	483,245	615,978		615,978	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	366	245,625	303	1,316,088		1,316,088	16
	Capital Expenses							
	D. Ownership							
17	Depreciation							17
18	Interest							18
19	Real Estate Taxes			102,150	102,150		102,150	19
20	Rent -- Facility and Grounds			779,805	779,805		779,805	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			881,955	881,955		881,955	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	366	245,625	882,258	2,198,042		2,198,042	24

Facility Name: The Glenwood of Greenville | Report Period Beginning: Jan 2020 | Ending: Dec 2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 23.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	4	12.25	3
4	Activity Director & Assistants	4	10.85	4
ID Number:			1000058	
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	19.97	12
13	Other Administrative	1	14.97	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	15	$	17

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

VII. RELATED ORGANIZATIONS

A. Enter below the names of all relat 366 ##

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).

Facility Name: The Glenwood of Greenville | Report Period Beginning: Jan 2020 | Ending: Dec 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
ID Number:			1000058								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

366 303

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: Colony 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*	
Facility ID Number:					1000058			
3	Building	Building	2006 38	11/1/2014	$ 779,805	5		3
4	Additions	Additions	2006 8	/ /				4
5			2007 10	/ /				5
6				/ /				6
7	TOTAL		56		$ 779,805			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 Name of Lender	2 Related** YES	NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1					/ /	$	$	/ /		$	1
2		366		303	/ /			/ /			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.

Facility Name: The Glenwood of Greenville
Report Period Beginning: Jan 2020 Ending: Dec 2020

XI. BALANCE SHEET - Unrestricted Operating Fund. As of Dec 2020 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 153,618	$	1
2	Cash-Patient Deposits	34,368		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	344,873		3
ID Number:		1000058		4
5	Short-Term Investments			5
6	Prepaid Insurance	105,186		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)**	$ 638,045	$	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	503,173		16
17	Accumulated Depreciation (book method 366	303		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)**	$ 503,476	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,141,520	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 126,537	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,368		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,101		30
31	Accrued Taxes Payable	101,935		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)**	$ 307,941	$	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)**	$ 307,941	$	45
46	**TOTAL EQUITY**	$ 775,370	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 1,083,311	$	47

*(See instructions.)

Facility Name: The Glenwood of Greenville Report Period Beginning: Jan 2020 Ending: Dec 2020

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

I.

	I. Revenue	1 Amount	
	A. SLF Resident Care		
	ID Number:		
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$	3
	B. Other Operating Revenue		
4	Special Services	5,000	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	357	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 5,357	11
	C. Non-Operating Revenue		
12	Contributions	366	12
13	Interest and Other Investment Income		13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 366	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)**	$ 5,723	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
1000058		342,213	19
20	Health Care/ Personal Care	357,896	20
21	General Administration	615,978	21
	B. Capital Expense		
22	Ownership	881,955	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)**	$ 2,198,042	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (2,192,319)	29
303			
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (2,192,319)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 415,617	32
33	Private Pay - Net Inpatient Revenue	1,758,412	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 2,174,029	37