

		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: 1000120

Facility Name: Greenview Place

Address: 1501 West Melrose Chicago 60657

County: Cook

Telephone Number: (773) 525-1501 Fax # (773) 269-6665

Federal Employer ID Number:

Date Current Owners were Certified: 7/13/10

Type of Ownership:

☐

VOLUNTARY, NON-PROFIT

☐

Charitable Corp.

☐

Trust

IRS Exemption Code

☒

PROPRIETARY

☐

Individual

☐

Partnership

☐

Corporation

☐

"Sub-S" Corp.

☐

Limited Liability Co.

☐

Trust

☒

Other

Limited Partnership

☐

GOVERNMENTAL

☐

State

☐

County

☐

Other

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

Name: Amanda Springborn Telephone Number: (314) 925-3838

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 01/01/2017 to 12/31/2017 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)

(Type or Print Name)

(Title)

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone)

(Date)

(Date)

RSM US LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173

(847) 517-7070 Fax (847) 517-7067

Paid Preparer

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

HFS 3745C (N-4-05)

IL478-2471

Facility Name Greenview Place

Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

Date of change in certified units N/A

	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	99	Single Unit Apartment	99	36,135	1
2	6	Double Unit Apartment	6	4,380	2
3		Other		2,190	3
4	105	TOTALS	105	42,705	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	32,115	2,021		34,136	5
6	Double Unit					6
7	Other					7
8	TOTALS	32,115	2,021		34,136	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 79.93%

D. Indicate the number of paid bed-hold days the SLF had during this year

714 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 78 (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)

None

H. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☒ YES ☐ NO

Tax Year: 12/31/17 Fiscal Year: 12/31/17

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding?

Yes If yes, did the facility make all of the required payments of interest and principle? Yes
If no, explain. N/A

K. Does the facility have any loans from the Federal Home Loan Bank outstanding?

Yes If yes, did the facility make all of the required payments of interest and principle? Yes
If no, explain. N/A

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? N/A
If no, explain. N/A

Facility Name: Greenview Place

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	289,141	245,184	2,699	537,024	74,461	611,485	1
2	Housekeeping, Laundry and Maintenance	133,304	22,221	75,617	231,142		231,142	2
3	Heat and Other Utilities			155,647	155,647		155,647	3
4	Other (specify):			3,977	3,977		3,977	4
5	TOTAL General Services	422,444	267,404	237,941	927,790	74,461	1,002,251	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	371,409	4,312	297,849	673,570	(75,093)	598,477	6
7	Activities and Social Services	39,606	123		39,729		39,729	7
8	Other (specify):			60,000	60,000		60,000	8
9	TOTAL Health Care and Programs	411,015	4,434	357,849	773,299	(75,093)	698,206	9
	C. General Administration							
10	Administrative and Clerical	491,503	19,265	654,647	1,165,415	(11,310)	1,154,105	10
11	Marketing Materials, Promotions and Advertising	75,843		9,322	85,165	(85,165)	0	11
12	Employee Benefits and Payroll Taxes			305,546	305,546		305,546	12
13	Insurance-Property, Liability and Malpractice			49,043	49,043		49,043	13
14	Other (specify):							14
15	TOTAL General Administration	567,346	19,265	1,018,559	1,605,170	(96,475)	1,508,695	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,400,806	291,103	1,614,349	3,306,258	(97,107)	3,209,151	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			611,700	611,700		611,700	17
18	Interest			493,396	493,396	(1,663)	491,733	18
19	Real Estate Taxes			135,756	135,756		135,756	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			3,919	3,919		3,919	21
22	Other (specify):			54,532	54,532	(54,532)		22
23	TOTAL Ownership			1,299,302	1,299,302	(56,195)	1,243,108	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,400,806	291,103	2,913,651	4,605,561	(153,302)	4,452,259	24

Facility Name: Greenview Place

Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	13.00	11.48	3
4	Activity Director & Assistants	2.21	15.35	4
5	Social Service Workers			5
6	Head Cook	2.96	12.26	6
7	Cook Helpers/Assistants			7
8	Dishwashers	9.00	11.08	8
9	Maintenance Workers	3.00	20.44	9
10	Housekeepers			10
11	Laundry			11
12	Managers	4.00	29.93	12
13	Other Administrative			13
14	Clerical	2.40	14.15	14
15	Marketing	1.00	36.53	15
16	Other			16
17	Total (lines 1 thru 16)	37.57	\$ 18.90	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
See Attached Schedule 1 (A)			

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	N/A			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	N/A	\$	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: N/A If yes, what is the value of those services? \$ N/A
(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: Greenview Place

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land 545,000 Year land was acquired 2009

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	105			2009	\$ 21,440,300	\$ 541,290	40	\$ 541,290	\$	\$ 4,430,083	1
2				2009	520,000	26,000	20	26,000		221,000	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)				\$ 21,960,300	\$ 567,290		\$ 567,290	\$	\$ 4,651,083	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	\$ 461,103	\$ 44,410	\$ 44,410	\$	10	\$ 320,581	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)		\$ 461,103	\$ 44,410	\$ 44,410	\$	\$ 320,581	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	N/A	\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)		\$	\$	24

Facility Name: Greenview Place

Report Period Beginning: 01/01/2017 Ending: 2/31/2017

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

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			/ /	\$ N/A			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				\$			7

8. Is movable equipment rental included in building rental?

YES NO

9. Rental amount for movable equipment \$ 3,919

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	DOH: Home Mortgage		X	Mortgage	4/1/08	\$ 2,800,000	\$ 2,800,000	6/1/48	0.0300	\$ 74,000	1
2	FHLB Mortgage		X	Mortgage	4/1/08	500,000	500,000	6/1/40			2
3	total from Attachment 2 (Line 5)				/ /	14,900,000	9,330,000	/ /		318,366	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 18,200,000	\$ 12,630,000			\$ 392,366	7
	B. Non-Facility Related										
8					/ /	Amortization Loan Fees		/ /		15,000	8
9					/ /	Total from Attachment 2 (line 10)		/ /		84,367	9
10	TOTALS (lines 7, 8 and 9)					\$ 18,200,000	\$ 12,630,000			\$ 491,733	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: **Greenview Place**Report Period Beginning: **01/01/2017**Ending: **12/31/2017****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2017

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 499,925	\$ 499,925	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	682,445	682,445	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,206,331	1,206,331	5
6	Prepaid Insurance	52,404	52,404	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)	\$ 2,441,105	\$ 2,441,105	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	545,000	545,000	13
14	Buildings, at Historical Cost	21,440,300	21,440,300	14
15	Leasehold Improvements, at Historical Cost	520,000	520,000	15
16	Equipment, at Historical Cost	461,103	461,103	16
17	Accumulated Depreciation (book methods)	(4,971,664)	(4,971,664)	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):	147,373	147,373	22
23	Other(specify): See Attachment #1B	138,840	138,840	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 18,280,952	\$ 18,280,952	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 20,722,058	\$ 20,722,058	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 26,605	\$ 26,605	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	131,348	131,348	31
32	Accrued Interest Payable	838,102	838,102	32
33	Deferred Compensation	220,600	220,600	33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Attachment #1C	169,615	169,615	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,386,270	\$ 1,386,270	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,300,000	4,300,000	39
40	Bonds Payable	8,330,000	8,330,000	40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Accrued Unrealized Loss on Swap	993,684	993,684	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 13,623,684	\$ 13,623,684	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 15,009,954	\$ 15,009,954	45
46	TOTAL EQUITY	\$ 5,712,104	\$ 5,712,104	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 20,722,058	\$ 20,722,058	47

*(See instructions.)

Facility Name: Greenview Place

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

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	\$ 3,910,235	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,910,235	3
	B. Other Operating Revenue		
4	Special Services		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	632	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 632	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	1,663	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,663	14
	D. Other Revenue (specify):		
15	See Attachment #1D	175,318	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 175,318	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,087,849	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	927,790	19
20	Health Care/ Personal Care	773,299	20
21	General Administration	1,605,170	21
	B. Capital Expense		
22	Ownership	1,299,302	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)	\$ 4,605,561	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (517,712)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (517,712)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 2,530,779	32
33	Private Pay - Net Inpatient Revenue	1,258,959	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Food Stamps</u>	120,497	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,910,235	37

Renaissance Saint Luke SLF, LP (D/B/A Greenview Place)
04-3848145

Supplementary Information - Attachment 1
12/31/2016

(A)

<u>Sch. VII-Related Parties-Related Nursing Homes</u>	
<u>Name</u>	<u>City</u>
Renaissance Realty	Chicago, IL
RRG Development	Chicago, IL
St Luke Church	Chicago, IL
Lutheran Community Services For The Aged, Inc	Chicago, IL
National Equity Fund	Chicago, IL
St. Luke Housing Ministries	Chicago, IL

(B)

<u>Sch. XI-Balance Sheet-Line 23: Other Current Liabilities</u>	<u>Operating</u>	<u>After Consolidation</u>
Legal Fees: Syndicator	33,000	33,000
Marketing and Leasing	100,000	100,000
Tax Credit Fees	5,840	5,840
	<u>138,840</u>	<u>138,840</u>

(C)

<u>Sch. XI-Balance Sheet-Line 35: Other Current Liabilities</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Management Fee	40,248	40,248
Security Deposit	2,250	2,250
Pet Deposit	2,220	2,220
Tenant Prepaid Rent	482	482
Tenant Deposits - Clearing	3,906	3,906
Clearing Account	21	21
Suspense	22,442	22,442
HFS Suspense	(6)	(6)
Prepaid Covered Services Mediciad	98,053	98,053
	<u>169,615</u>	<u>169,615</u>

(D)

<u>Sch. XII. Income Statement-Line 15: Other Revenue</u>	<u>Amount</u>
Parking	24,601
Key & Lock Charges	10
Miscellaneous Income	11,310
Unrealized Loss on Swap	139,397
	<u>175,318</u>

	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note				Maturity Date	Interest Rate (4 Digits)	Reporting Period		
		YES	NO			Original	Balance	Int. Expense						
	A. Directly Facility Related													
	Long-Term													
3	IHDA Trust Fund Mortgage		X	Mortgage	4/1/08	\$ 1,000,000	\$ 1,000,000		6/1/40	0.0100	\$ 10,000		3	
4	Series A Bond		X	Mortgage	4/1/08	13,900,000	8,330,000		6/1/40	0.0363	308,366		4	
5	Total (Attachment 2) to Schedule X - Line 3				/ /	14,900,000	9,330,000		/ /		318,366		5	
	B. Non-Facility Related													
8					/ /	Interest Income			/ /		(1,663)		8	
9					/ /	Letter of Credit Expense			/ /		86,030		9	
	Total (Attachment 2) to Schedule X - Line 9										84,367			