

		FOR BHF USE			

LL2

Supportive Living Facility

2019

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2019)

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		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Greenview Place</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2019</u> to <u>12/31/2019</u> and certify to the best of my knowledge and belief that the said content 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	
Address: <u>1501 West Melrose</u> <u>Chicago</u> <u>60657</u>			
County: <u>Cook</u>			
Telephone Number: <u>(773) 525-1501</u> Fax # <u>773 269-6665</u>			
Federal Employer ID Number: _____			
Date Current Owners were Certified: <u>7/13/10</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☒ Other <u>Limited Partnership</u> ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other _____		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>CohnReznick, LLP</u> <u>200 S. Wacker Drive, Suite 2600, Chicago, IL 60606</u> (Telephone) <u>(312) 508-5900</u> Fax # <u>(312) 508-5901</u>	
In the event there are further questions about this report, please contact:		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	
Name: <u>Jeff Dowd</u> Telephone Number: <u>(312) 508-5444</u>			
Email Address: _____			

III. STATISTICAL DATA

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

Date of change in certified unitsN/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			3
4	105	TOTALS	105	40,515	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	32,396	1,610		34,006	5
6	Double Unit	2,361			2,361	6
7	Other					7
8	TOTALS	34,757	1,610		36,367	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.)89.76%

D. Indicate the number of paid bed-hold days the SLF had during this year620 Also, indicate the number of unpaid bed-hold days the SLF had during this year.28 (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?
YESXNO

F. Does the BALANCE SHEET reflect any non-SLF assets?
YESNONOX

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

H. ACCOUNTING BASIS
ACCRUALXMODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year?XYESNONO
Tax Year: 12/31/2019Fiscal Year: 12/31/2019
* 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 principal? 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 principal? 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 principal? N/A
If no, explain. N/A

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	410,011	240,111	675	650,797		650,797	1
2	Housekeeping, Laundry and Maintenance	139,022	29,453	66,398	234,873		234,873	2
3	Heat and Other Utilities			144,978	144,978		144,978	3
4	Other (specify):			16,730	16,730		16,730	4
5	TOTAL General Services	549,033	269,564	228,781	1,047,378		1,047,378	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	611,783	3,931	517	616,231		616,231	6
7	Activities and Social Services	44,542			44,542		44,542	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	656,325	3,931	517	660,773		660,773	9
	C. General Administration							
10	Administrative and Clerical	523,141	14,056	473,359	1,010,556		1,010,556	10
11	Marketing Materials, Promotions and Advertising	81,299		12,069	93,368		93,368	11
12	Employee Benefits and Payroll Taxes			353,199	353,199		353,199	12
13	Insurance-Property, Liability and Malpractice			160,323	160,323		160,323	13
14	Other (specify):							14
15	TOTAL General Administration	604,440	14,056	998,950	1,617,446		1,617,446	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,809,798	287,551	1,228,248	3,325,597		3,325,597	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			610,172	610,172		610,172	17
18	Interest			491,201	491,201	(4,696)	486,505	18
19	Real Estate Taxes			135,182	135,182		135,182	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			4,034	4,034		4,034	21
22	Other (specify):			143,824	143,824	(143,824)		22
23	TOTAL Ownership			1,384,413	1,384,413	(148,520)	1,235,893	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,809,798		2,612,661	4,710,010	(148,520)	4,561,490	24

Facility Name: Greenview Place

Report Period Beginning 01/01/2019 Ending: 12/31/2019

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.06	\$ 31.67	1
2	Licensed Practical Nurses	2.94	25.59	2
3	Certified Nurse Assistants	10.19	13.18	3
4	Activity Director & Assistants	1.22	19.18	4
5	Social Service Workers			5
6	Head Cook	1.00	33.17	6
7	Cook Helpers/Assistants	3.29	13.94	7
8	Dishwashers	9.06	13.33	8
9	Maintenance Workers	3.12	20.87	9
10	Housekeepers			10
11	Laundry			11
12	Managers	4.00	34.00	12
13	Other Administrative			13
14	Clerical	2.66	16.56	14
15	Marketing	1.00	39.13	15
16	Other	1.05	15.00	16
17	Total (lines 1 thru 16)	40	\$ 17.23	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	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

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)	

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
N/A		

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:

01/01/2019

Ending:

12/31/2019

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	\$	\$ 5,512,663	1
2				2009	520,000	26,000	20	26,000		273,000	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	\$	\$ 5,785,663	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	\$ 409,401	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 461,103	\$ 44,410	\$ 44,410	\$		\$ 409,401	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: Greenview Place

Report Period Beginning: 01/01/2019 Ending: 2/31/2019

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 \$ 3,846

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	4/01/08	\$ 2,800,000	\$ 2,800,000	6/01/48	0.0300	\$ 84,000	1
2	FHLB Mortgage		X	Mortgage	4/01/08	500,000	500,000	6/01/40			2
3	Total from Attachment 2 (Line 5)				/ /	14,900,000	9,030,000	/ /		306,487	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 18,200,000	\$ 12,330,000			\$ 390,487	7
	B. Non-Facility Related										
8					/ /	Amortization Loan Fees		/ /		14,979	8
9					/ /	Total from Attachment 2 (line 10)		/ /		81,039	9
10	TOTALS (lines 7, 8 and 9)					\$ 18,200,000	\$ 12,330,000			\$ 486,505	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 247,856	\$ 247,856	1
2	Cash-Patient Deposits	5,320	5,320	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,205,850	1,205,850	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,132,909	1,132,909	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)	\$ 2,644,339	\$ 2,644,339	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)	(6,182,839)	(6,182,839)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): Deferred Costs	100,873	100,873	22
23	Other(specify): See attachment#1B	138,840	138,840	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,023,277	\$ 17,023,277	24
25	TOTAL ASSETS (sum of lines 10 and 24)	19,667,616	\$ 19,667,616	25

*(See instructions.)

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,050	\$ 5,050	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	987,498	987,498	32
33	Deferred Compensation	439,790	439,790	33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See attachment #IC	349,704	349,704	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,913,390	\$ 1,913,390	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,300,000	4,300,000	39
40	Bonds Payable	8,030,000	8,030,000	40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Accrued Unrealized Loss on Swap	949,450	949,450	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 13,279,450	\$ 13,279,450	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 15,192,840	\$ 15,192,840	45
46	TOTAL EQUITY	\$ 4,474,776	\$ 4,474,776	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 19,667,616	\$ 19,667,616	47

Facility Name: Greenview Place

Report Period Beginning: 01/01/2019 Ending: 12/31/2019

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	\$ 4,273,815	1
2	Discounts and Allowances		2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 4,273,815	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	562	9
10	Laundry		10
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$ 562	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	4,696	13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$ 4,696	14
	D. Other Revenue (specify):		
15			15
16			16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 4,279,073	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,047,378	19
20	Health Care/ Personal Care	660,773	20
21	General Administration	1,617,446	21
	B. Capital Expense		
22	Ownership	1,384,413	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	See Attachment #1D	113,400	26
27			27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 4,823,410	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ (544,337)	29
30	Income Taxes	\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ (544,337)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 2,636,809	32
33	Private Pay - Net Inpatient Revenue	1,540,668	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Food Stamps</u>	96,338	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 4,273,815	37

Supplementary Information - Attachment 1
12/31/2019

(A)	Sch. VII-Related Parties-Related Nursing Homes		
	<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	19,571	19,571
	Security Deposit	2,475	2,475
	Pet Deposit	929	929
	Tenant Prepaid Rent	5,255	5,255
	Tenant Deposits - Clearing	4,142	4,142
	Clearing Account	21	21
	Suspense	22,442	22,442
	HFS Suspense	(6)	(6)
	Prepaid Covered Services Medicaid	294,875	294,875
		<u>349,704</u>	<u>349,704</u>
(D)	<u>Sch. XII. Income Statement-Line 26: Other Expenses</u>	<u>Amount</u>	
	Parking	21,590	
	Miscellaneous Income	11,325	
	Unrealized Loss on Swap	<u>(146,315)</u>	
		<u>(113,400)</u>	

	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										
3	IHDA Trust Fund Mortgage		X	Mortgage	4/01/08	\$ 1,000,000	\$ 1,000,000	6/01/40	0.0100	\$ 10,000	3
4	Series A Bond		X	Mortgage	4/01/08	13,900,000	8,030,000	6/01/40	0.0363	296,487	4
5	Total (Attachment 2) to Schedule X - Line 3				/ /	14,900,000	9,030,000	/ /		306,487	5
	B. Non-Facility Related										
8					/ /	Interest Income		/ /		-4,696	8
9					/ /	Letter of Credit Expense		/ /		85,735	9
10	TOTALS (lines 7, 8 and 9)									\$ 81,039	10