

		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: 1000148

Facility Name: New City Supportive Living

Address: 4707 S Ashland Ave Chicago 60609

County: Cook

Telephone Number: (773) 376-1223 Fax # (773) 376-1226

Federal Employer ID Number: _____

Date Current Owners were Certified: 8/23/16

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
 IRS Exemption Code _____

☒ PROPRIETARY
☐ Individual
☒ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other _____

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other _____

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

Name: Larry Templin Telephone Number: (630) 361-2868
 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 1/1/20 to 12/31/20 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) _____ (Date) _____
 (Type or Print Name) _____
 (Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S COMPILATION REPORT (Date) _____
 (Print Name and Title) Larry Templin
Partner
 (Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 326, Plainfield, IL 60544-0326
 (Telephone) (630) 361-2868 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

HFS 3745C (N-4-05)

IL478-2471

Facility Name New City Supportive Living Report Period Beginning: 1/1/20 Ending: 12/31/20

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	86	Single Unit Apartment	86	31,476	1
2	15	Double Unit Apartment	15	5,490	2
3		Other			3
4	101	TOTALS	101	36,966	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	26,978	547		27,525	5
6	Double Unit	4,151	308		4,459	6
7	Other					7
8	TOTALS	31,129	855		31,984	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 86.52%

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

1,280 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 146 (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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

* 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? No
If no, explain. N/A

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? N/A
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

STATE OF ILLINOIS

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Facility Name: New City Supportive Living

Report Period Beginning:

1/1/20

Ending:

12/31/20

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		231,397	3,895	235,292	302,493	537,785	1
2	Housekeeping, Laundry and Maintenance		39,637	227,336	266,973	127,342	394,315	2
3	Heat and Other Utilities			172,656	172,656	21,098	193,754	3
4	Other (specify): Trash Expense			22,833	22,833		22,833	4
5	TOTAL General Services		271,034	426,720	697,754	450,933	1,148,687	5
	B. Health Care and Programs							
6	Health Care/ Personal Care		4,054	15,150	19,204	522,645	541,849	6
7	Activities and Social Services			3,242	3,242	35,109	38,351	7
8	Other (specify):							8
9	TOTAL Health Care and Programs		4,054	18,392	22,446	557,754	580,200	9
	C. General Administration							
10	Administrative and Clerical		5,634	2,347,017	2,352,651	(1,580,547)	772,104	10
11	Marketing Materials, Promotions and Advertising		478	43,455	43,933	63,745	107,678	11
12	Employee Benefits and Payroll Taxes			2,497	2,497	332,873	335,370	12
13	Insurance-Property, Liability and Malpractice			141,979	141,979	9,342	151,321	13
14	Other (specify):							14
15	TOTAL General Administration		6,112	2,534,948	2,541,060	(1,174,587)	1,366,473	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)		281,200	2,980,060	3,261,260	(165,900)	3,095,360	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			1,014,161	1,014,161		1,014,161	17
18	Interest			1,377,182	1,377,182	(168,483)	1,208,699	18
19	Real Estate Taxes			114,389	114,389		114,389	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			6,886	6,886		6,886	21
22	Other (specify): Amortization of Tax Credit/Loan Fees			64,978	64,978		64,978	22
23	TOTAL Ownership			2,577,596	2,577,596	(168,483)	2,409,113	23
24	GRAND TOTAL (Sum of lines 16 and 23)		281,200	5,557,656	5,838,856	(334,383)	5,504,473	24

Facility Name: New City Supportive Living

Report Period Beginning 1/1/20 Ending: 12/31/20

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.75	\$ 29.55	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	12.75	15.27	3
4	Activity Director & Assistants	1.00	15.74	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	10.00	14.53	7
8	Dishwashers			8
9	Maintenance Workers	0.75	31.88	9
10	Housekeepers	2.75	14.31	10
11	Laundry			11
12	Managers	2.00	38.12	12
13	Other Administrative	2.75	15.47	13
14	Clerical	0.75	24.41	14
15	Marketing	1.00	31.00	15
16	Other			16
17	Total (lines 1 thru 16)	35.50	\$ 17.95	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
New City Service Provider LLC		Chicago		Payroll Services	

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).

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	5T Management, Inc.	\$ 195,753	1
2			2
Total		\$ 195,753	3

Facility Name: New City Supportive Living

Report Period Beginning:

1/1/20

Ending:

12/31/20

VIII. OWNERSHIP COSTS

A. Purchase price of land 1,172,390 Year land was acquired 2013

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	101		2015	2015	\$ 36,107,546	\$ 902,689	40	\$ 902,689	\$	\$ 4,736,802	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Leasehold Improvements			2015	186,741	9,337	20	9,337		46,935	6
7	Leasehold Improvements			2016	20,000	1,000	20	1,000		4,583	7
8	Floor Replacement			2019	18,352	459	40	459		535	8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 36,332,639	\$ 913,485		\$ 913,485	\$	\$ 4,788,855	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	\$ 1,023,447	\$ 100,676	\$ 100,676	\$	10	\$ 491,086	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 1,023,447	\$ 100,676	\$ 100,676	\$		\$ 491,086	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: New City Supportive Living Report Period Beginning: 1/1/20 Ending: 12/31/20

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		8. Is movable equipment rental included in building rental?
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*		YES NO
3	Original Building			/ /	\$ N/A			3	
4	Additions			/ /				4	
5				/ /				5	
6				/ /				6	
7	TOTAL				\$			7	
									9. Rental amount for movable equipment \$ N/A
									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	City of Chicago Bonds		X	First Mortgage	1/1/13	\$ 18,000,000	17,700,000	12/1/52	0.0625	1,120,358	1
2	Affordable Housing Continuum		X	Second Mortgage	1/30/13	988,011	988,011	12/1/54	0.0231	22,823	2
3	See Attached Schedule 6A				/ /	8,568,300	6,137,300	/ /		67,924	3
	Working Capital										
4	Celadon Holdings LLC	X		Working Capital	/ /	300,000	300,000	/ /	0.0500	15,000	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 27,856,311	\$ 25,125,311			\$ 1,226,105	7
	B. Non-Facility Related										
8					/ /		Disallow R/P Int	/ /		(15,000)	8
9					/ /		Offset Int Inc	/ /		(2,406)	9
10	TOTALS (lines 7, 8 and 9)					\$ 27,856,311	\$ 25,125,311			\$ 1,208,699	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: New City Supportive Living Report Period Beginning: 1/1/2020 Ending: 12/31/2020

Schedule 6A
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	Affordable Housing Continuum		X	Third Mortgage	1/30/13	\$ 2,248,300	\$ 2,248,300	12/1/54	0.0231	\$ 51,936	1
2	City of Chicago Bonds		X	Fourth Mortgage	12/1/12	1,000,000	989,000	12/1/54	None		2
3	AHC Ashland LLC		X	Fifth Mortgage	1/30/13	2,900,000	2,900,000	12/1/54	None		
4	City of Chicago Bonds		X	Sixth Mortgage	5/1/15	2,420,000		12/1/30	0.0800	15,988	
5											
6											
7											3
13											9
14	TOTALS (lines 7, 8 and 9)					\$ 8,568,300	\$ 6,137,300			\$ 67,924	10

STATE OF ILLINOIS

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Facility Name: New City Supportive Living

Report Period Beginning: 1/1/20

Ending:

12/31/20

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 15,658	\$ 15,658	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 336,164)	934,639	934,639	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	111,007	111,007	6
7	Other Prepaid Expenses	28,238	28,238	7
8	Accounts Receivable (owners or related parties)	36,633	36,633	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,126,175	\$ 1,126,175	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,172,390	1,172,390	13
14	Buildings, at Historical Cost	36,107,546	36,107,546	14
15	Leasehold Improvements, at Historical Cost	226,841	225,093	15
16	Equipment, at Historical Cost	1,023,448	1,023,447	16
17	Accumulated Depreciation (book methods)	(5,279,941)	(5,279,941)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	36,497	36,497	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(19,162)	(19,162)	20
21	Restricted Funds	681,722	681,722	21
22	Other Long-Term Assets Security Deposit	914	914	22
23	Other(specify): <u>Loan Fees, Net</u>	1,093,891	1,093,891	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 35,044,146	\$ 35,042,397	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 36,170,321	\$ 36,168,572	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 254,766	\$ 254,766	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	36,955	36,955	31
32	Accrued Interest Payable	1,540,996	1,540,996	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>See Attached Schedule I</u>	4,027,600	4,027,600	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 5,860,317	\$ 5,860,317	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	300,000	300,000	38
39	Mortgage Payable	24,825,311	24,825,311	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)	\$ 25,125,311	\$ 25,125,311	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 30,985,628	\$ 30,985,628	45
46	TOTAL EQUITY	\$ 5,184,693	\$ 5,182,944	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 36,170,321	\$ 36,168,572	47

*(See instructions.)

Facility Name: New City Supportive Living

Report Period Beginning: 1/1/20

Ending:

12/31/20

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	\$ 4,099,544	1
2	Discounts and Allowances	(135,412)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,964,132	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	61,166	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 61,166	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	2,406	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,406	14
	D. Other Revenue (specify):		
15	See Attached Schedule I	13,118	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 13,118	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,040,822	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	697,754	19
20	Health Care/ Personal Care	22,446	20
21	General Administration	2,541,060	21
	B. Capital Expense		
22	Ownership	2,577,596	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)	\$ 5,838,856	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (1,798,034)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (1,798,034)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 3,079,904	32
33	Private Pay - Net Inpatient Revenue	779,216	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Food Stamps</u>	105,012	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,964,132	37

New City Supportive Living

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule I

XI. Balance Sheet

	Line 35 Other Current Liabilities	
	Operating	After Consolidation
Accrued Expenses	73,955	73,955
Accrued Developer Fees	3,021,533	3,021,533
Accrued Partnership Mgmt Fee	273,419	273,419
Accrued Asset Mgmt Fee	95,537	95,537
Accrued Mgmt Fees	55,024	55,024
Due to General Partner	577,087	577,087
Prepaid Rent	8,364	8,364
Prepaid Medicaid Clearing	(77,319)	(77,319)
TOTAL	4,027,600	4,027,600

XII. Income Statement

Line 15 Other Revenue		Amount
Cable Income	5,466	Offset Against Cable Expense
Phone Income	4,562	Offset Against Telephone Exp
Tenant Fees	35	
Refunds from Vendors	3,055	
TOTAL	13,118	

Adjustment Detail

Line	Description	Amount
2	Expense Minor Capitalized Items	1,748
3	Offset Cable Income Against Cable TV Expense	(5,466)
10	Offset Phone Income Against Telephone Expense	(4,562)
10	Disallow Related Party Management Fees	(74,354)
10	Disallow Bad Debt Expense	(472,514)
18	Offset Interest Income Against Expense	(2,406)
18	Disallow Related Party Interest Expense	(166,077)
Various	Record Provider Service Entity Expenses	389,248
Total Adjustments		(334,383)

FACILITY NAME: New City Supportive Living

BEGINNING:

1/1/20

ENDING:

12/31/20

ATTACHED SCHEDULE IIADJUSTMENT FOR SERVICE PROVIDER COSTS
SUMMARY SCHEDULE

Sch. IV Line #		Salaries	Other	Total
1	Dietary and Food	302,493	0	302,493
2	Hskp, Laundry, Main	125,594	0	125,594
3	Heat & Other Utilities	0	26,564	26,564
4	Other	0	0	-
6	Health Care/persona	522,645	0	522,645
7	Activities & Soc Serv	35,109	0	35,109
8	Other	0	0	-
10	Admin/Clerical	292,405	18,919	311,324
11	Mkt, Promo, Adv	63,161	584	63,745
12	Emp Ben & PR taxes	0	332,873	332,873
13	Insurance	0	9,342	9,342
14	Other	0	0	-
17	Depreciation	0	0	-
18	Interest	0	0	-
19	Real Estate Taxes	0	0	-
				-
				-

TOTAL EXPENSES	1,341,407	388,282	1,729,689
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Provider Service Fee Expense	(1,340,441)
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Net adjustment required	<u>389,248</u>
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