

		FOR BHF USE			

LL2

Supportive Living Facility

2021

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2021)

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

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

☐ GOVERNMENTAL State County Other

IRS Exemption Code

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

Name: Jeff Dowd

Telephone Number: (312) 508-5444

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 01/01/2021 to 12/31/2021 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)

Paid Preparer

(Signed)

(Print Name and Title) Jeff Dowd, CPA
Partner

(Firm Name & Address) CohnReznick, LLLP
200 S. Wacker Drive, Suite 2600, Chicago, IL 60606

(Telephone) (312)) 508-5900 Fax (312) 508-5901

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 PlaceReport Period Beginning: 01/01/2021 Ending: 12/31/2021**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			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	27,922	1,154		29,076	5
6	Double Unit	3,657			3,657	6
7	Other					7
8	TOTALS	31,579	1,154		32,733	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 80.79%

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

516 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 1827 (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)****H. ACCOUNTING BASIS**

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☒ YES ☐ NOTax Year: 12/31/2021 Fiscal Year: 12/31/2021

* 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

STATE OF ILLINOIS

Page 3

Facility Name: Greenview Place

Report Period Beginning:

01/01/2021

Ending:

12/31/2021

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	423,729	283,656	700	708,085		708,085	1
2	Housekeeping, Laundry and Maintenance	150,761	26,395	61,335	238,491		238,491	2
3	Heat and Other Utilities			143,099	143,099		143,099	3
4	Other (specify):			14,407	14,407		14,407	4
5	TOTAL General Services	574,490	310,051	219,541	1,104,082		1,104,082	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	708,229	9,335		717,564		717,564	6
7	Activities and Social Services	69,177			69,177		69,177	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	777,406	9,335		786,741		786,741	9
	C. General Administration							
10	Administrative and Clerical	533,988	17,926	484,759	1,036,673		1,036,673	10
11	Marketing Materials, Promotions and Advertising	86,153		8,368	94,521		94,521	11
12	Employee Benefits and Payroll Taxes			360,160	360,160		360,160	12
13	Insurance-Property, Liability and Malpractice			132,281	132,281		132,281	13
14	Other (specify):							14
15	TOTAL General Administration	620,141	17,926	985,568	1,623,635		1,623,635	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,972,037	337,312	1,205,109	3,514,458		3,514,458	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			564,508	564,508		564,508	17
18	Interest			465,885	465,885	(1,263)	464,622	18
19	Real Estate Taxes			150,536	150,536		150,536	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			4,465	4,465		4,465	21
22	Other (specify):			20,763	20,763	(20,763)		22
23	TOTAL Ownership			1,206,157	1,206,157	(22,026)	1,184,131	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,972,037	337,312	2,411,266	4,720,615	(22,026)	4,698,589	24

Facility Name: Greenview Place

Report Period Beginning: 01/01/2021 Ending: 12/31/2021

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.96	\$ 41.64	1
2	Licensed Practical Nurses	2	27.02	2
3	Certified Nurse Assistants	12	15.17	3
4	Activity Director & Assistants	2	20.46	4
5	Social Service Workers			5
6	Head Cook	1	35.19	6
7	Cook Helpers/Assistants	3	15.10	7
8	Dishwashers	8	14.80	8
9	Maintenance Workers	3	23.19	9
10	Housekeepers			10
11	Laundry			11
12	Managers	4	35.84	12
13	Other Administrative	1	16.17	13
14	Clerical	2	26.99	14
15	Marketing	1	41.51	15
16	Other			16
17	Total (lines 1 thru 16)	40	\$	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? \$ (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:

01/01/2021

Ending:

12/31/2021

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	105			2009	\$ 21,440,300	\$	40	\$ 494,098	\$ 494,098	\$ 6,500,859	1
2				2009	520,000	26,000	20	26,000		325,000	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	\$ 26,000		\$ 520,098	\$ 494,098	\$ 6,825,859	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	\$ 7,292	\$ 7,292	\$	10	\$ 461,103	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 461,103	\$ 7,292	\$ 7,292	\$		\$ 461,103	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: 01/01/2021 Ending: 2/31/2021

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 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			/ /	\$ 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 \$ 4,465

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	8,670,000	/ /		293,563	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 18,200,000	\$ 11,970,000			\$ 377,563	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 18,200,000	\$ 11,970,000			\$ 377,563	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: 01/01/2021

Ending: 12/31/2021

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2021

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 206,202	\$ 206,202	1
2	Cash-Patient Deposits	5,220	5,220	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	652,555	652,555	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,311,845	1,311,845	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)	\$ 2,228,226	\$ 2,228,226	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)	(7,311,855)	(7,311,855)	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):	76,999	76,999	22
23	Other(specify): See attachment#1B	138,840	138,840	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,870,387	\$ 15,870,387	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 18,098,613	\$ 18,098,613	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 7,310	\$ 7,310	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	1,155,498	1,155,498	32
33	Deferred Compensation	315,537	315,537	33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See attachment #1C	98,101	98,101	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,707,794	\$ 1,707,794	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,300,000	4,300,000	39
40	Bonds Payable	7,670,000	7,670,000	40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Accrued Unrealized Loss on Swap	691,429	691,429	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 12,661,429	\$ 12,661,429	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 14,369,223	\$ 14,369,223	45
46	TOTAL EQUITY	\$ 3,729,390	\$ 3,729,390	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 18,098,613	\$ 18,098,613	47

*(See instructions.)

Facility Name: Greenview Place

Report Period Beginning: 01/01/2021

Ending:

12/31/2021

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	\$ 3,950,529	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,950,529	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		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	1,264	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,264	14
	D. Other Revenue (specify):		
15	See Attachment #1D	464,129	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 464,129	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,415,922	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,104,082	19
20	Health Care/ Personal Care	786,741	20
21	General Administration	1,623,635	21
	B. Capital Expense		
22	Ownership	1,206,157	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)	\$ 4,720,615	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (304,693)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (304,693)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 2,579,443	32
33	Private Pay - Net Inpatient Revenue	1,177,521	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Food Stamps</u>	193,565	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,950,529	37

tary Information - Attachment 1

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

Sch. XI-Balance Sheet-Line 23: Other Current Liabilities

	<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
	138,840	138,840

Sch. XI-Balance Sheet-Line 35: Other Current Liabilities

	<u>Operating</u>	<u>After Consolidation</u>
Accrued Management Fee	20,763	20,763
Security Deposit	875	875
Pet Deposit	804	804
Tenant Prepaid Rent	6,238	6,238
Tenant Deposits - Clearing	4,965	4,965
Clearing Account	3,448	3,448
Suspense	0	0
HFS Suspense	(6)	(6)
Prepaid Covered Services Medicaid	61,014	61,014
	98,101	98,101

Sch. XII. Income Statement-Line 26: Other Expenses

	<u>Amount</u>
Parking	(250)
Paycheck Protection Program (PPP) - proceeds	-

pense (continued)

	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note	
		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
4	Series A Bond		X	Mortgage	4/01/08	13,900,000	7,670,000
5	Total (Attachment 2) to Schedule X - Line 3				/ /	14,900,000	8,670,000
	B. Non-Facility Related						
8					/ /	Interest Income	
9					/ /	Letter of Credit Expense	
10	TOTALS (lines 7, 8 and 9)						