FOR BHF USE

LL2

Supportive Living Facility

2016

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)

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 (Number) Chicago (City) 60657 (Zip Code)

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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
		X	Other Limited Partnership		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 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) (Date)

(Print Name and Title)

(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

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**

Facility Name Greenview Place Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units N/A

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	99	Single Unit Apartment	99	36,234	1
2	6	Double Unit Apartment	6	4,392	2
3		Other		2,196	3
4	105	TOTALS	105	42,822	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	31,629	1,616		33,245	5
6	Double Unit					6
7	Other					7
8	TOTALS	31,629	1,616		33,245	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 77.64%

D. Indicate the number of paid bed-hold days the SLF had during this year 454 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 1 **(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 [X] NO [ ]

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)
None

H. ACCOUNTING BASIS

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

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/16 Fiscal Year: 12/31/16
* 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: 01/01/2016 Ending: 12/31/2016**

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

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	287,516	234,478	650	522,644	64,932	587,576	1
2	Housekeeping, Laundry and Maintenance	123,069	20,351	157,125	300,545		300,545	2
3	Heat and Other Utilities			157,128	157,128		157,128	3
4	Other (specify):			15,184	15,184		15,184	4
5	**TOTAL General Services**	410,585	254,829	330,087	995,501	64,932	1,060,433	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	340,764	6,913	303,599	651,276	(65,745)	585,530	6
7	Activities and Social Services	30,546	477		31,023		31,023	7
8	Other (specify):			60,000	60,000		60,000	8
9	**TOTAL Health Care and Programs**	371,311	7,389	363,599	742,298	(65,745)	676,553	9
	C. General Administration							
10	Administrative and Clerical	461,391	20,922	342,761	825,074	(15,586)	809,488	10
11	Marketing Materials, Promotions and Advertising	72,363		10,629	82,992	(82,992)	(0)	11
12	Employee Benefits and Payroll Taxes			286,699	286,699		286,699	12
13	Insurance-Property, Liability and Malpractice			59,039	59,039		59,039	13
14	Other (specify):							14
15	**TOTAL General Administration**	533,754	20,922	699,128	1,253,803	(98,578)	1,155,225	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,315,649	283,140	1,392,813	2,991,602	(99,391)	2,892,211	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			611,700	611,700		611,700	17
18	Interest			502,532	502,532	(4,426)	498,106	18
19	Real Estate Taxes			117,473	117,473		117,473	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			3,549	3,549		3,549	21
22	Other (specify):			104,306	104,306	(104,306)	(0)	22
23	**TOTAL Ownership**			1,339,559	1,339,559	(108,732)	1,230,827	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,315,649	283,140	2,732,372	4,331,161	(208,123)	4,123,038	24

Facility Name: Greenview Place **Report Period Beginning: 01/01/2016 Ending: 12/31/2016**

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	12.89	10.83	3
4	Activity Director & Assistants	2.25	15.42	4
5	Social Service Workers			5
6	Head Cook	2.50	13.13	6
7	Cook Helpers/Assistants			7
8	Dishwashers	8.29	10.75	8
9	Maintenance Workers	3.00	20.19	9
10	Housekeepers			10
11	Laundry			11
12	Managers	4.00	28.62	12
13	Other Administrative			13
14	Clerical	1.50	14.15	14
15	Marketing	1.00	34.79	15
16	Other			16
17	Total (lines 1 thru 16)	35.43	$ 18.49	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				OTHER RELATED BUSINESS ENTITIES					
Name	1	City	2	Name	3	City	4	Type of Business	5
See Attached Schedule 1 (A)				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 [X]

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 [X]

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: 01/01/2016 Ending: 12/31/2016

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	$	$ 3,888,793	1
2				2009	520,000	26,000	20	26,000		195,000	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	$	$ 4,083,793	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	$ 276,171	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 461,103	$ 44,410	$ 44,410	$		$ 276,171	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:** 01/01/2016 **Ending:** 2/31/2016

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 [X] 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 [X] NO

9. Rental amount for movable equipment $ 3,549

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	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	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	9,480,000	/ /		325,719	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 18,200,000	$ 12,780,000			$ 399,719	7
	B. Non-Facility Related										
8					/ /	Amortization Loan Fees		/ /		15,000	8
9					/ /	Total from Attachment 2 (line 10)		/ /		83,387	9
10	TOTALS (lines 7, 8 and 9)					$ 18,200,000	$ 12,780,000			$ 498,106	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:** 01/01/2016 **Ending:** 12/31/2016

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 214,523	$ 214,523	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	873,531	873,531	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,235,960	1,235,960	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)**	$ 2,376,417	$ 2,376,417	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)	(4,359,964)	(4,359,964)	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):	162,373	162,373	22
23	Other(specify): See Attachment #1B	138,840	138,840	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 18,907,652	$ 18,907,652	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 21,284,070	$ 21,284,070	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 37,924	$ 37,924	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	115,000	115,000	31
32	Accrued Interest Payable	764,102	764,102	32
33	Deferred Compensation	73,600	73,600	33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Attachment #1C	150,547	150,547	35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 1,141,173	$ 1,141,173	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,300,000	4,300,000	39
40	Bonds Payable	8,480,000	8,480,000	40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Accrued Unrealized Loss on Swap	1,133,081	1,133,081	42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 13,913,081	$ 13,913,081	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 15,054,254	$ 15,054,254	45
46	**TOTAL EQUITY**	$ 6,229,815	$ 6,229,815	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 21,284,070	$ 21,284,070	47

***(See instructions.)**

Facility Name: Greenview Place **Report Period Beginning: 01/01/2016 Ending: 12/31/2016**

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 3,635,767	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 3,635,767	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	813	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 813	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	4,426	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 4,426	14
	D. Other Revenue (specify):		
15	**See Attachment #1D**	392,099	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 392,099	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 4,033,104	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	995,501	19
20	Health Care/ Personal Care	742,298	20
21	General Administration	1,253,803	21
	B. Capital Expense		
22	Ownership	1,339,559	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)**	$ 4,331,161	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (298,057)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (298,057)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 2,184,837	32
33	Private Pay - Net Inpatient Revenue	1,336,797	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) **Food Stamps**	114,133	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 3,635,767	37

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

Supplementary Information - Attachment 1
12/31/2016

(A) Sch. VII-Related Parties-Related Nursing Homes

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

	Operating	After Consolidation
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

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

	Operating	After Consolidation
Accrued Management Fee	22,210	22,210
Security Deposit	3,050	3,050
Pet Deposit	1,500	1,500
Tenant Prepaid Rent	468	468
Tenant Deposits - Clearing	4,289	4,289
Clearing Account	21	21
Suspense	22,442	22,442
HFS Suspense	(6)	(6)
Prepaid Covered Services Mediciad	96,573	96,573
	150,547	150,547

(D) Sch. XII. Income Statement-Line 15: Other Revenue

	Amount
Late Fees	159
Parking	26,296
Key & Lock Charges	30
Miscellaneous Income	17,995
Pet Usage Fee	65
Unrealized Loss on Swap	347,554
	392,099

Renaissance Saint Luke SLF, LP (D/B/A Greenview Place)
Interest Expense (continued)
12/31/2016 **Attachment 2**

	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period 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	8,480,000	6/1/40	0.0363	315,719	4
5	Total (Attachment 2) to Schedule X - Line 3				/ /	14,900,000	9,480,000	/ /		325,719	5
	B. Non-Facility Related										
8					/ /	Interest Income		/ /		(4,421)	8
9					/ /	Letter of Credit Expense		/ /		87,808	9
	Total (Attachment 2) to Schedule X - Line 9									83,387	