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: 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		

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 01/01/2020 to 12/31/2020 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)	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**

Facility Name Greenview Place Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	36,135	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 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	29,889	2,283		32,172	5
6	Double Unit	3,099			3,099	6
7	Other					7
8	TOTALS	32,988	2,283		35,271	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 87.06%

D. Indicate the number of paid bed-hold days the SLF had during this year 399 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 18 (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)

H. ACCOUNTING BASIS
ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* 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? 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

Facility Name: Greenview Place **Report Period Beginning: 01/01/2020 Ending: 12/31/2020**

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	405,566	299,867	1,678	707,111		707,111	1
2	Housekeeping, Laundry and Maintenance	149,660	22,015	92,147	263,822		263,822	2
3	Heat and Other Utilities			141,160	141,160		141,160	3
4	Other (specify):			15,811	15,811		15,811	4
5	**TOTAL General Services**	555,226	321,882	250,796	1,127,904		1,127,904	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	639,179	4,710		643,889		643,889	6
7	Activities and Social Services	44,206			44,206		44,206	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	683,385	4,710		688,095		688,095	9
	C. General Administration							
10	Administrative and Clerical	580,689	14,802	508,629	1,104,120		1,104,120	10
11	Marketing Materials, Promotions and Advertising	85,485		3,505	88,990		88,990	11
12	Employee Benefits and Payroll Taxes			351,759	351,759		351,759	12
13	Insurance-Property, Liability and Malpractice			192,506	192,506		192,506	13
14	Other (specify):							14
15	**TOTAL General Administration**	666,174	14,802	1,056,399	1,737,375		1,737,375	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,904,785	341,394	1,307,195	3,553,374		3,553,374	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			564,508	564,508		564,508	17
18	Interest			481,264	481,264	(2,448)	478,816	18
19	Real Estate Taxes			135,969	135,969		135,969	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			4,253	4,253		4,253	21
22	Other (specify):			498,208	498,208	(498,208)		22
23	**TOTAL Ownership**			1,684,202	1,684,202	(500,656)	1,183,546	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,904,785	341,394	2,991,397	5,237,576	(500,656)	4,736,920	24

Facility Name: Greenview Place Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.50	$ 30.90	1
2	Licensed Practical Nurses	3.71	26.99	2
3	Certified Nurse Assistants	14.79	15.05	3
4	Activity Director & Assistants	1.05	20.36	4
5	Social Service Workers			5
6	Head Cook	1.00	35.19	6
7	Cook Helpers/Assistants	3.41	14.97	7
8	Dishwashers	7.93	14.17	8
9	Maintenance Workers	3.28	23.19	9
10	Housekeepers			10
11	Laundry			11
12	Managers	4.00	36.65	12
13	Other Administrative			13
14	Clerical	2.62	17.79	14
15	Marketing	1.00	41.51	15
16	Other			16
17	Total (lines 1 thru 16)	43.29	$ 18.45	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? $
(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: 01/01/2020 Ending: 12/31/2020

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	$	40	$ 494,098	$ 494,098	$ 6,006,761	1
2				2009	520,000	26,000	20	26,000		299,000	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	$ 6,305,761	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	$ 453,811	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 461,103	$ 44,410	$ 44,410	$		$ 453,811	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:** 01/01/2020 **Ending:** 2/31/2020

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 $ 4,253

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	4/01/08	$ 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	8,850,000	/ /		300,788	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 18,200,000	$ 12,150,000			$ 384,788	7
	B. Non-Facility Related										
8					/ /	Amortization Loan Fees		/ /		14,979	8
9					/ /	Total from Attachment 2 (line 10)		/ /		79,049	9
10	TOTALS (lines 7, 8 and 9)					$ 18,200,000	$ 12,150,000			$ 478,816	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:** 01/01/2020 **Ending:** 12/31/2020

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 939,426	$ 939,426	1
2	Cash-Patient Deposits	4,620	4,620	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	632,043	632,043	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,346,073	1,346,073	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)**	$ 2,974,566	$ 2,974,566	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)	(6,747,347)	(6,747,347)	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): Deferred Costs	85,894	85,894	22
23	Other(specify): See attachment#1B	138,840	138,840	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 16,443,790	$ 16,443,790	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 19,418,356	$ 19,418,356	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	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	1,071,498	1,071,498	32
33	Deferred Compensation	793,587	793,587	33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See attachement #1C	95,130	95,130	35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 2,091,563	$ 2,091,563	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,300,000	4,300,000	39
40	Bonds Payable	7,850,000	7,850,000	40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Accrued Unrealized Loss on Swap	1,089,533	1,089,533	42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 13,239,533	$ 13,239,533	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 15,331,096	$ 15,331,096	45
46	**TOTAL EQUITY**	$ 4,087,260	$ 4,087,260	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 19,418,356	$ 19,418,356	47

***(See instructions.)**

Facility Name: Greenview Place **Report Period Beginning: 01/01/2020 Ending: 12/31/2020**

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	$ 4,361,074	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 4,361,074	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	265	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 265	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	2,448	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 2,448	14
	D. Other Revenue (specify):		
15	**See Attachment #1D**	512,518	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 512,518	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 4,876,305	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	1,127,904	19
20	Health Care/ Personal Care	688,095	20
21	General Administration	1,737,375	21
	B. Capital Expense		
22	Ownership	1,684,202	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)**	$ 5,237,576	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (361,271)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (361,271)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 2,843,833	32
33	Private Pay - Net Inpatient Revenue	1,372,379	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) **Food Stamps**	144,862	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 4,361,074	37

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

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

Sch. XI-Balance Sheet-Line 35: Other Current Liabilities	Operating	After Consolidation
Accrued Management Fee	20,158	20,158
Security Deposit	875	875
Pet Deposit	503	503
Tenant Prepaid Rent	6,615	6,615
Tenant Deposits - Clearing	4,815	4,815
Clearing Account	-3,067	-3,067
Suspense	22,442	22,442
HFS Suspense	(6)	(6)
Prepaid Covered Services Medicaid	42,795	42,795
	95,130	95,130

Sch. XII. Income Statement-Line 26: Other Expenses	Amount
Parking	3,689
Paycheck Protection Program (PPP) - proceeds	595,489
Miscellaneous Income	53,423

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	7,850,000
5	Total (Attachment 2) to Schedule X - Line 3				/ /	14,900,000	8,850,000
	B. Non-Facility Related						
8					/ /	Interest Income	
9					/ /	Letter of Credit Expense	
10	TOTALS (lines 7, 8 and 9)						