

		FOR BHF USE			

LL2

Supportive Living Facility

**2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2012)**

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.

<p>I. Facility ID Number: <u>1000120</u></p> <p>Facility Name: <u>Greenview Place</u></p> <p>Address: <u>1501 West Melrose</u> <u>Chicago</u> <u>60657</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: (<u>773</u>) <u>525-1501</u> Fax # <u>(773) 269-6665</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>7/13/10</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Other <u>Limited Partnership</u></td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input checked="" type="checkbox"/> Other <u>Limited Partnership</u>		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) _____ (Title) _____ </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) <u>(847) 517-7070</u> Fax <u>(847) 517-7067</u> </td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>McGladrey LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u> (Telephone) <u>(847) 517-7070</u> Fax <u>(847) 517-7067</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name Greenview Place

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

III. STATISTICAL DATA

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

Date of change in certified units / /

	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	105	Single Unit Apartment	105	38,430	1
2		Double Unit Apartment			2
3		Other		2,196	3
4	105	TOTALS	105	40,626	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	28,190	3,146		31,336	5
6	Double Unit					6
7	Other	1,100	732		1,832	7
8	TOTALS	29,290	3,878		33,168	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 81.64%

D. Indicate the number of paid bed-hold days the SLF had during this year
612 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? Note : Non-allowable costs have been eliminated in Schedule IV, Column 5.
 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

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO
 Tax Year: 12/31/12 Fiscal Year: 12/31/12

* 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:

1/1/12

Ending:

12/31/12

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	245,049	214,013		459,063	50,278	509,341	1
2	Housekeeping, Laundry and Maintenance	100,301	25,285	68,310	193,895		193,895	2
3	Heat and Other Utilities			109,899	109,899		109,899	3
4	Other (specify):			2,973	2,973	(2,973)		4
5	TOTAL General Services	345,350	239,299	181,182	765,830	47,305	813,135	5
B. Health Care and Programs								
6	Health Care/ Personal Care	269,960	9,758	277,164	556,882	(52,578)	504,304	6
7	Activities and Social Services	39,000	428	219	39,647		39,647	7
8	Other (specify):			60,000	60,000		60,000	8
9	TOTAL Health Care and Programs	308,960	10,186	337,383	656,529	(52,578)	603,951	9
C. General Administration								
10	Administrative and Clerical	289,254	17,239	207,304	513,797	(15,687)	498,110	10
11	Marketing Materials, Promotions and Advertising	59,000		23,405	82,405	(82,405)	0	11
12	Employee Benefits and Payroll Taxes			257,911	257,911		257,911	12
13	Insurance-Property, Liability and Malpractice			53,945	53,945		53,945	13
14	Other (specify):							14
15	TOTAL General Administration	348,254	17,239	542,566	908,059	(98,092)	809,967	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,002,564	266,724	1,061,131	2,330,418	(103,365)	2,227,053	16
Capital Expenses								
D. Ownership								
17	Depreciation			611,700	611,700		611,700	17
18	Interest			551,815	551,815	(4,626)	547,189	18
19	Real Estate Taxes			136,772	136,772		136,772	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			3,540	3,540		3,540	21
22	Other (specify):			239,170	239,170	(239,170)	(0)	22
23	TOTAL Ownership			1,542,996	1,542,996	(243,796)	1,299,200	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,002,564	266,724	2,604,127	3,873,415	(347,161)	3,526,254	24

Facility Name: Greenview Place

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

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	10.12	3
4	Activity Director & Assistants	1.00	18.75	4
5	Social Service Workers			5
6	Head Cook	2.64	12.73	6
7	Cook Helpers/Assistants			7
8	Dishwashers	14.47	9.18	8
9	Maintenance Workers	2.40	16.43	9
10	Housekeepers			10
11	Laundry			11
12	Managers	3.50	25.57	12
13	Other Administrative			13
14	Clerical	1.72	11.52	14
15	Marketing	1.00	28.37	15
16	Other			16
17	Total (lines 1 thru 16)	39.62	\$ 16.58	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	\$
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:

1/1/12

Ending:

12/31/12

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	\$ 541,291	40	\$ 541,291	\$	\$ 1,744,223	1
2				2009	520,000	26,000	20	26,000		26,000	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	\$ 567,291		\$ 567,291	\$	\$ 1,770,223	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	\$ 44,409	\$ 44,409	\$	10	\$ 142,941	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 461,103	\$ 44,409	\$ 44,409	\$		\$ 142,941	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: 1/1/12

Ending: 12/31/12

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 \$ 3,540

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		3	4	6		7	8	9	
			Related**	YES			NO	Purpose of Loan				
							Original	Balance				
		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	\$ 94,000	1
2		FHLB Mortgage		X	Mortgage	4/1/08	500,000	500,000	6/1/40			2
3		Total from Attachment 2 (line 14)				/ /	14,900,000	10,080,000	/ /		349,054	3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 18,200,000	\$ 13,380,000			\$ 443,054	7
		B. Non-Facility Related										
8						/ /	Amortization loan fees		/ /		15,000	8
9						/ /	Total from attachment 2 (line 19)		/ /		89,136	9
10		TOTALS (lines 7, 8 and 9)					\$ 18,200,000	\$ 13,380,000			\$ 547,189	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: **1/1/12**

Ending:

12/31/12**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/12

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 389,021	\$ 389,021	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u>)	1,059,348	1,059,348	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments	786,494	786,494	5
6	Prepaid Insurance	31,989	31,989	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,266,852	\$ 2,266,852	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)	(1,913,164)	(1,913,164)	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): <u>Bond Costs</u>	222,373	222,373	22
23	Other(specify): <u>Legal Fees & Leasing</u>	138,840	138,840	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,414,453	\$ 21,414,453	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 23,681,305	\$ 23,681,305	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 30,818	\$ 30,818	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	150,000	150,000	31
32	Accrued Interest Payable	448,102	448,102	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>See Attachment 1B</u>	56,708	56,708	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 685,627	\$ 685,627	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,300,000	4,300,000	39
40	Bonds Payable	9,080,000	9,080,000	40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	<u>See Attachment 1C</u>	2,583,872	2,583,872	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 15,963,872	\$ 15,963,872	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 16,649,499	\$ 16,649,499	45
46	TOTAL EQUITY	\$ 7,031,806	\$ 7,031,806	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 23,681,305	\$ 23,681,305	47

*(See instructions.)

Facility Name: Greenview Place

Report Period Beginning: 1/1/12

Ending:

12/31/12

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 3,570,743	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,570,743	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	2,300	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 2,300	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	4,626	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 4,626	14
D. Other Revenue (specify):			
15	See Attachment #1D	41,931	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 41,931	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,619,600	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	765,830	19
20	Health Care/ Personal Care	656,529	20
21	General Administration	908,059	21
B. Capital Expense			
22	Ownership	1,542,996	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)	\$ 3,873,415	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (253,814)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (253,814)	31

Greenview Place**0**

Supplementary Information - Attachment 1

12/31/2012

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

	<u>Operating</u>	<u>After Consolidation</u>
Accrued Asset Management fee	46,364	46,364
Security Deposit	2,496	2,496
Pet Deposit	777	777
Tenant Prepaid Rent	2,976	2,976
Tenant Deposits - Clearing	4,095	4,095
	<u>56,708</u>	<u>56,708</u>

(C) Sch. XI-Balance Sheet-Line 42: Other Long-Term Liabilities

	<u>Operating</u>	<u>After Consolidation</u>
Accrued Developers Fee	771,645	771,645
Accrued Unrealized Loss on Swap	1,812,227	1,812,227
	<u>2,583,872</u>	<u>2,583,872</u>

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

Late Fees	161
NSF Fee	175
Parking	26,023
Key & Lock Charges	185
Damage & Cleaning Charges	85
Miscellaneous Income	15,256
Pet Usage Fee	46
	<u>41,931</u>

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

Interest Expense (continued)

12/31/2012

Attachment 2

	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	4/1/08	\$ 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	9,080,000	6/1/40	0.0363	339,054	4
5	Total (Attachment 2) to Schedule X - Line 3				/ /	14,900,000	10,080,000	/ /		349,054	5
B. Non-Facility Related											
8					/ /	Interest Income		/ /		(4,626)	8
9					/ /	Letter of Credit Expense		/ /		93,762	9
	Total (Attachment 2) to Schedule X - Line 9									89,136	