FOR BHF USE

LL2

Supportive Living Facility

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2015)

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: 1000146

Facility Name: Eden Supportive Lvg Champgn

Address: 222 North State St (Number) Champaign (City) 61820 (Zip Code)

County: Champaign

Telephone Number: (217) 903-5900 **Fax #** (217) 378-6829

Federal Employer ID Number:

Date Current Owners were Certified: 10/31/2014

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mitch Hamblet **Telephone Number:** (217) 903-5900
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 01/01/2015 to 12/31/2015 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) Michael J. Hamblet, Jr.
(Title) Managing Member

Paid Preparer

(Signed) (Date)
(Print Name and Title) Paul H. Wieland, President
(Firm Name & Address) Wieland & Company, Inc., 201 Houston St., Suite 301, Batavia, IL 60510
(Telephone) (630) 406-4490 Fax # (630) 406-4491

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: Eden Supportive Lvg Champgn Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

Date of change in certified units: 12/31 /15

	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	148	Single Unit Apartment	148	54,020	1
2	2	Double Unit Apartment	4	1,460	2
3		Other			3
4	150	TOTALS	152	55,480	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	43,938	367		44,305	5
6	Double Unit	730			730	6
7	Other					7
8	TOTALS	44,668	367		45,035	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 81.17%

D. Indicate the number of paid bed-hold days the SLF had during this year 2 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 7 **(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 [X]

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: 12/31/2015 Fiscal Year: 12/31/2015
* 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 principle?** _____
If no, explain.

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 principle?** _____
If no, explain.

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?** _____
If no, explain.

Facility Name: Eden Supportive Lvg Champgn **Report Period Beginning: 01/01/2015 Ending: 12/31/2015**

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	225,248	284,067		509,315		509,315	1
2	Housekeeping, Laundry and Maintenance	133,723	31,077	86,267	251,067		251,067	2
3	Heat and Other Utilities			132,768	132,768		132,768	3
4	Other (specify):							4
5	**TOTAL General Services**	358,971	315,144	219,035	893,150		893,150	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	316,048	2,899		318,947		318,947	6
7	Activities and Social Services	32,046		24,730	56,776		56,776	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	348,094	2,899	24,730	375,723		375,723	9
	C. General Administration							
10	Administrative and Clerical	395,186	28,724	97,399	521,309		521,309	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			150,805	150,805		150,805	12
13	Insurance-Property, Liability and Malpractice			44,343	44,343		44,343	13
14	Other (specify):							14
15	**TOTAL General Administration**	395,186	28,724	292,547	716,457		716,457	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,102,251	346,767	536,312	1,985,330		1,985,330	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			787,063	787,063		787,063	17
18	Interest			616,894	616,894		616,894	18
19	Real Estate Taxes			52,485	52,485		52,485	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			91,499	91,499		91,499	22
23	**TOTAL Ownership**			1,547,941	1,547,941		1,547,941	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,102,251	346,767	2,084,253	3,533,271		3,533,271	24

Facility Name: Eden Supportive Lvg Champgn Report Period Beginning 01/01/2015 Ending: 12/31/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 26.44	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	13	10.95	3
4	Activity Director & Assistants	2	13.81	4
5	Social Service Workers			5
6	Head Cook	1	10.39	6
7	Cook Helpers/Assistants	4	9.23	7
8	Dishwashers	1	9.00	8
9	Maintenance Workers	2	12.27	9
10	Housekeepers	2	9.20	10
11	Laundry	2	9.50	11
12	Managers	5	24.30	12
13	Other Administrative	1	14.78	13
14	Clerical	4	10.75	14
15	Marketing	1	16.83	15
16	Other			16
17	Total (lines 1 thru 16)	39	$ 13.65	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	No compensation paid to owners during 2015			$	1
2					2
3					3
4					4
5					5
			Total	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	None	$	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
Eden Supportive Living-Chicago	Chicago, IL			Supportive living
Eve Assisted Living	Hinsdale, IL			Assisted living
Eden Fox Valley	North Aurora, IL			Supportive living

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: _____ 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: Eden Supportive Lvg Champgn Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	150		2013	2013-2014	$ 20,682,671	$ 648,009	40	$ 648,009	$	$ 1,457,527	1
2											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)				$ 20,682,671	$ 648,009		$ 648,009	$	$ 1,457,527	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	$ 712,032	$ 139,054	$ 139,054	$	5	$ 307,950	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 712,032	$ 139,054	$ 139,054	$		$ 307,950	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: Eden Supportive Lvg Champgn **Report Period Beginning:** 01/01/2015 **Ending:** 2/31/2015

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: _____

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			/ /	$			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 $ _____

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

	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	Oak Grove Capital		X	Acquisition/construction/rehab	6/1/12	$ 14,203,987	$ 13,997,826	8/1/53	3.7600	$ 529,193	1
2	2012B Bonds-surplus cash		X	Purchase money	6/1/12	1,000,000	965,940	4/1/29	9.0000	87,701	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 15,203,987	$ 14,963,766			$ 616,894	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 15,203,987	$ 14,963,766			$ 616,894	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: Eden Supportive Lvg Champgn **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 980,913	$	1
2	Cash-Patient Deposits	17,185		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance none)	851,974		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	65,086		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,915,158	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	340,000		13
14	Buildings, at Historical Cost	20,682,671		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	712,032		16
17	Accumulated Depreciation (book methods)	(1,765,477)		17
18	Deferred Charges	434,065		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	202,108		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 20,605,399	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 22,520,557	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 115,937	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,545		28
29	Short-Term Notes Payable	37,125		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	50,500		31
32	Accrued Interest Payable	109,061		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35		172,038		35
36		19,760		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 519,966	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	13,825,788		39
40	Bonds Payable	928,815		40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Deferred developer fee	2,250,000		42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 17,004,603	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 17,524,569	$	45
46	**TOTAL EQUITY**	$ 4,995,988	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 22,520,557	$	47

***(See instructions.)**

Facility Name: Eden Supportive Lvg Champgn **Report Period Beginning: 01/01/2015 Ending: 12/31/2015**

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

	Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 3,717,640	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 3,717,640	3
	B. Other Operating Revenue		
4	Special Services	21,321	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)**	$ 21,321	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	21	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 21	14
	D. Other Revenue (specify):		
15			15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 3,738,982	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	893,150	19
20	Health Care/ Personal Care	375,723	20
21	General Administration	716,457	21
	B. Capital Expense		
22	Ownership	1,547,941	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)**	$ 3,533,271	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 205,711	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 205,711	31

Eden Supportive Living of Champaign
01/01/2015 to 12/31/2015

STATEMENT 1 PART IV, LINE 22, COLUMN 3 - OTHER OWNERSHIP

Mortgage insurance premium	$ 80,020
Miscellaneous financial expense	56
Amortization expense	11,423
	$ 91,499