

		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.

<p><b>I. Facility ID Number:</b> <u>1000102</u></p> <p><b>Facility Name:</b> <u>Eden Supportive Lvg N Aurora</u></p> <hr/> <p><b>Address:</b> <u>311 South Lincolnway</u> <u>North Aurora</u> <u>60542</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>Kane</u></p> <p><b>Telephone Number:</b> <u>( 630 )</u> <b>Fax #</b> <u>( 630 )</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>08/06/08</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</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 checked="" 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 type="checkbox"/> Other _____</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>Mitch Hamblet</u> <b>Telephone Number:</b> <u>( 630 )</u></p> <p><b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input checked="" type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other _____	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</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%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Michael J. Hamblet, Jr.</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Managing Member</u></td> <td></td> </tr> <tr> <td></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Print Name and Title) <u>Paul H. Wieland President</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Wieland &amp; Company, Inc. 201 Houston Street, Suite 301, Batavia, IL 60510</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(630 ) 406-4490</u> Fax # <u>( 630 ) 406-4491</u></td> <td></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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>Michael J. Hamblet, Jr.</u>			(Title) <u>Managing Member</u>			(Signed) _____	(Date) _____	<b>Paid Preparer</b>	(Print Name and Title) <u>Paul H. Wieland President</u>			(Firm Name & Address) <u>Wieland &amp; Company, Inc. 201 Houston Street, Suite 301, Batavia, IL 60510</u>			(Telephone) <u>(630 ) 406-4490</u> Fax # <u>( 630 ) 406-4491</u>	
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Facility Name: Eden Supportive Lvg N Aurora

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 1	Supplies 2	Other 3	Total 4			
<b>A. General Services</b>								
1	Dietary and Food Purchase	303,221	310,464		613,685		613,685	1
2	Housekeeping, Laundry and Maintenance	268,442	65,878	104,863	439,183		439,183	2
3	Heat and Other Utilities			236,005	236,005		236,005	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	571,663	376,342	340,868	1,288,873		1,288,873	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	367,401	3,675		371,076		371,076	6
7	Activities and Social Services	36,336	3,806	23,584	63,726		63,726	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	403,737	7,481	23,584	434,802		434,802	9
<b>C. General Administration</b>								
10	Administrative and Clerical	378,032	20,372	92,807	491,211		491,211	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			219,567	219,567		219,567	12
13	Insurance-Property, Liability and Malpractice			130,930	130,930		130,930	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	378,032	20,372	443,304	841,708		841,708	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	1,353,432	404,195	807,756	2,565,383		2,565,383	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			340,892	340,892		340,892	17
18	Interest			350,353	350,353		350,353	18
19	Real Estate Taxes			39,779	39,779		39,779	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			317,050	317,050		317,050	22
23	<b>TOTAL Ownership</b>			1,048,074	1,048,074		1,048,074	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	1,353,432	404,195	1,855,830	3,613,457		3,613,457	24

Facility Name: Eden Supportive Lvg N Aurora

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	\$ 30.77	1
2	Licensed Practical Nurses	1	25.49	2
3	Certified Nurse Assistants	10	10.86	3
4	Activity Director & Assistants	2	13.19	4
5	Social Service Workers			5
6	Head Cook	3	14.25	6
7	Cook Helpers/Assistants	4	9.06	7
8	Dishwashers	1	9.01	8
9	Maintenance Workers	3	13.60	9
10	Housekeepers	4	10.64	10
11	Laundry	1	13.71	11
12	Managers	4	28.65	12
13	Other Administrative	1	13.72	13
14	Clerical			14
15	Marketing	1	27.25	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>36</b>	<b>\$</b>	<b>17</b>

**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	Affiliate Asset management fees		40	\$ 44,900	1	
2					2	
3					3	
4					4	
5					5	
				<b>Total</b>	<b>\$ 44900</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

	Amount of Fee	
1	None	\$ 1
2		2
<b>Total</b>		<b>\$ 3</b>

**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
Eden Supportive Living-Chicago		Chicago, IL	
Eden Supportive Living-Champaign		Champaign, IL	
Eve Assisted Living		Hinsdale, IL	

**OTHER RELATED BUSINESS ENTITIES**

Name	3	City	4	Type of Business	5
				Supportive Living	
				Supportive Living	
				Assisted 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

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

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 N Aurora

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VIII. OWNERSHIP COSTS

A. Purchase price of land 430,771 Year land was acquired 2006

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		2006	2006-2007	\$ 6,457,047	\$ 234,778	28	\$ 234,778	\$	\$ 1,966,298	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	Rehab and construction		2006	2007-2008	2,052,059		5			2,052,059	6
7	Rehab and construction		2006	2007-2008	411,673		7			411,673	7
8	Rehab and construction		2006	2007-2008	900,585	60,069	15	60,069		510,541	8
9	Rehab and construction		2009	2009	7,400	269	28	269		2,118	9
10	Rehab and construction		2010	2010	49,616	1,804	28	1,804		12,553	10
11	Rehab and construction		2011	2011	2,510	91	28	91		504	11
12	Rehab and construction		2012	2012	13,609	495	28	495		2,454	12
13	Rehab and construction		2014	2014	8,408	1,682	5	1,682		4,205	13
14	Rehab and construction		2015	2015	50,190	1,825	28	1,825		2,053	14
15	Rehab and construction		2015	2015	23,050	2,190	15	2,190		3,343	15
16	Rehab and construction		2016	2016	197,191	8,152	28	8,152		8,152	16
17	TOTAL (lines 1 thru 16)				\$ 10,173,338	\$ 311,355		\$ 311,355	\$	\$ 4,975,953	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	\$	\$ 29,537	\$ 29,537	\$	5 to 7	\$ 143,465	18
19	Vehicles	19,172				5	19,172	19
20	TOTAL (lines 18 and 19)		\$ 19,172	\$ 29,537	\$ 29,537		\$ 162,637	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 N Aurora

Report Period Beginning: 01/01/2016

Ending: 2/31/2016

**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	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			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	<b>TOTAL</b>				\$			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**

	1	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		<b>A. Directly Facility Related</b>										
		<b>Long-Term</b>										
1		Hsng and Healthcare Fin.		X	Acquisition/construction/rehab/refi	6/15/12	\$ 11,344,500	\$ 10,525,083	7/1/47	3.3000	\$ 350,353	1
2						/ /			/ /			2
3						/ /			/ /			3
		<b>Working Capital</b>										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		<b>TOTAL Facility Related</b>					\$ 11,344,500	\$ 10,525,083			\$ 350,353	7
		<b>B. Non-Facility Related</b>										
8						/ /			/ /			8
9						/ /			/ /			9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 11,344,500	\$ 10,525,083			\$ 350,353	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 N Aurora

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	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,918,713	\$	1
2	Cash-Patient Deposits	142,862		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,092,965		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,894		6
7	Other Prepaid Expenses	27,267		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 5,243,701</b>	<b>\$</b>	<b>10</b>
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	430,771		13
14	Buildings, at Historical Cost	10,173,338		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	218,602		16
17	Accumulated Depreciation (book methods)	(5,138,590)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	515,567		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 6,199,688</b>	<b>\$</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 11,443,389</b>	<b>\$</b>	<b>25</b>

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 83,217	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	139,434		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,853		30
31	Accrued Taxes Payable	102,000		31
32	Accrued Interest Payable	28,944		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	Current portion of mortgage payable	202,690		35
36	Accounts payable, entity	4,563		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	<b>\$ 598,701</b>	<b>\$</b>	<b>37</b>
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	10,181,164		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	<b>\$ 10,181,164</b>	<b>\$</b>	<b>44</b>
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	<b>\$ 10,779,865</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL EQUITY</b>	<b>\$ 663,524</b>	<b>\$</b>	<b>46</b>
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	<b>\$ 11,443,389</b>	<b>\$</b>	<b>47</b>

\*(See instructions.)

Facility Name: Eden Supportive Lvg N Aurora

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.)

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 5,860,428	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 5,860,428</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
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	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	11,664	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 11,664</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	Commercial rents	13,200	15
16	Other revenues	62,758	16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 75,958</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 5,948,050</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	1,288,873	19
20	Health Care/ Personal Care	434,802	20
21	General Administration	841,708	21
<b>B. Capital Expense</b>			
22	Ownership	1,048,074	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 3,613,457</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 2,334,593</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 2,334,593</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 3,719,566	32
33	Private Pay - Net Inpatient Revenue	2,140,862	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 5,860,428</b>	<b>37</b>



**Eden Fox Valley**  
**01/01/2016 to 12/31/2016**

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

Mortgage insurance premium	\$ 52,992
Asset management fees	44,900
Entity expense - legal	214,515
Amortization expense	<u>4,643</u>
	<u>\$317,050</u>