FOR BHF USE

LL2

Supportive Living Facility

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)

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 Supportve Lvg Champaign

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: 10/31/14

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:** (312) 263-7347
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 1/1/17 to 12/31/17 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 Street, Ste 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 Supportve Lvg Champaign Report Period Beginning: 1/1/17 Ending: 12/31/17

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units 12/31/2017

	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	54,020	54,020	1
2	2	Double Unit Apartment	730	730	2
3		Other			3
4	150	TOTALS	54,750	54,750	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	47,664	763	2,743	51,170	5
6	Double Unit	601			601	6
7	Other					7
8	TOTALS	48,265	763	2,743	51,771	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 94.56%

D. Indicate the number of paid bed-hold days the SLF had during this year ____ **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 1006 **(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? [ ] YES [ ] NO
Tax Year: 12/31/17 Fiscal Year: 12/31/17
* 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 Supportve Lvg Champaign **Report Period Beginning: 1/1/17 Ending: 12/31/17**

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	291,823	360,248		652,071		652,071	1
2	Housekeeping, Laundry and Maintenance	178,707	57,600	116,119	352,426		352,426	2
3	Heat and Other Utilities			159,834	159,834		159,834	3
4	Other (specify):							4
5	**TOTAL General Services**	470,530	417,848	275,953	1,164,331		1,164,331	5
	B. Health Care and Programs							
6	Health Care/ Personal Care		2,615		2,615		2,615	6
7	Activities and Social Services			19,371	19,371		19,371	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**		2,615	19,371	21,986		21,986	9
	C. General Administration							
10	Administrative and Clerical	337,310	48,658	43,667	429,635		429,635	10
11	Marketing Materials, Promotions and Advertising			7,209	7,209		7,209	11
12	Employee Benefits and Payroll Taxes			161,183	161,183		161,183	12
13	Insurance-Property, Liability and Malpractice			55,845	55,845		55,845	13
14	Other (specify): Bad debt			730,000	730,000		730,000	14
15	**TOTAL General Administration**	337,310	48,658	997,904	1,383,872		1,383,872	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	807,840	469,121	1,293,228	2,570,189		2,570,189	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			794,271	794,271		794,271	17
18	Interest			608,520	608,520		608,520	18
19	Real Estate Taxes			114,042	114,042		114,042	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			63,436	63,436		63,436	22
23	**TOTAL Ownership**			1,580,269	1,580,269		1,580,269	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	807,840	469,121	2,873,497	4,150,458		4,150,458	24

Facility Name: Eden Supportve Lvg Champaign Report Period Beginnin 1/1/17 Ending: 12/31/17

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 28.36	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	13	12.47	3
4	Activity Director & Assistants	2	14.42	4
5	Social Service Workers			5
6	Head Cook	1	24.51	6
7	Cook Helpers/Assistants	12	10.40	7
8	Dishwashers			8
9	Maintenance Workers	2	13.48	9
10	Housekeepers	5	9.81	10
11	Laundry			11
12	Managers	4	26.32	12
13	Other Administrative			13
14	Clerical	4	17.30	14
15	Marketing	2	16.08	15
16	Other			16
17	Total (lines 1 thru 16)	46	$ 17.32	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	Affiliate Asset management fees		40	$ 46,370	1
2					2
3					3
4					4
5					5
			Total	$ 46,370	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1		$	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
Eden Supportive Living - South Shore	Chicago, IL			

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES [X] NO [ ]
Name of related entity: Eden Services Inc. If yes, what is the value of those services? $ 52,038
(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 Supportve Lvg Champaign Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. OWNERSHIP COSTS

A. Purchase price of land 340,000 Year land was acquired 2013

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	$ 20,697,005	$ 650,058	40	$ 650,058	$	$ 2,756,618	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Flooring		2017		3,022	54	7	54		54	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)				$ 20,700,027	$ 650,112		$ 650,112	$	$ 2,756,672	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	$ 721,496	$ 144,159	$ 144,159	$	5	$ 595,349	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 721,496	$ 144,159	$ 144,159	$		$ 595,349	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 Supportve Lvg Champaign **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

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

	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	Oak Grove Capital		X	Acquisition/construction/rehab	6/1/12	$ 14,203,987	$ 13,235,949	8/1/53	3.7600	$ 516,233	1
2	2012B Bonds-surplus cash		X	Purchase money	6/1/12	1,000,000	888,348	4/1/29	9.0000	80,864	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 15,203,987	$ 14,124,297			$ 597,097	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 15,203,987	$ 14,124,297			$ 597,097	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 Supportve Lvg Champaign **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,120,302	$	1
2	Cash-Patient Deposits	16,902		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 730,000)	2,917,542		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	41,082		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,095,828	$	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	20,700,026		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	721,496		16
17	Accumulated Depreciation (book methods)	(3,352,021)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	496,017		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 18,905,518	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 23,001,346	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 75,795	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,044		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,173		30
31	Accrued Taxes Payable	83,700		31
32	Accrued Interest Payable	102,724		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Current portion of mortgage payable	185,453		35
36	Current portion of surplus cash note	44,109		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 540,998	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	844,239		38
39	Mortgage Payable	13,050,496		39
40	Bonds Payable			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)**	$ 16,144,735	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 16,685,733	$	45
46	**TOTAL EQUITY**	$ 6,315,613	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 23,001,346	$	47

***(See instructions.)**

Facility Name: Eden Supportve Lvg Champaign **Report Period Beginning: 1/1/17 Ending: 12/31/17**

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	$ 5,020,951	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 5,020,951	3
	B. Other Operating Revenue		
4	Special Services	673	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)**	$ 673	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	80	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 80	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)**	$ 5,021,704	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	1,164,331	19
20	Health Care/ Personal Care	21,986	20
21	General Administration	1,383,872	21
	B. Capital Expense		
22	Ownership	1,580,269	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)**	$ 4,150,458	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 871,246	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 871,246	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 1,649,995	32
33	Private Pay - Net Inpatient Revenue	3,370,956	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 5,020,951	37

Eden Supportive Living of Champaign
01/01/2016 to 12/31/2016

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

Mortgage insurance premium	$ (27)
Miscellaneous financial expense	-
Entity expense - legal	-
Asset management fees	52,040
Amortization expense	11,423
	$ 63,436