FOR BHF USE

LL2

Supportive Living Facility

2018

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)

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: 1000155

Facility Name: Eden South Shore

Address: 7156 S Dorchester Av (Number) | Chicago (City) | 60619 (Zip Code)

County: Cook

Telephone Number: (773) 466-6868 **Fax #** (773) 466-6833

Federal Employer ID Number:

Date Current Owners were Certified: 11/6/17

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:** (630) 929-3333
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 1/1/18 to 12/31/18 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, 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 South Shore Report Period Beginning: 1/1/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	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	130	Single Unit Apartment	130	47,450	1
2	10	Double Unit Apartment	10	3,650	2
3		Other			3
4	140	TOTALS	140	51,100	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	32,706	274		32,980	5
6	Double Unit	2,380			2,380	6
7	Other					7
8	TOTALS	35,086	274		35,360	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 69.20%

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.
(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	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/18 Fiscal Year: 12/31/18
* 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 principal?
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 principal?
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 principal?
If no, explain.

Facility Name: Eden South Shore **Report Period Beginning: 1/1/18 Ending: 12/31/18**

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	257,751	268,496		526,247		526,247	1
2	Housekeeping, Laundry and Maintenance	143,599	43,463	95,254	282,316		282,316	2
3	Heat and Other Utilities			160,572	160,572		160,572	3
4	Other (specify):							4
5	**TOTAL General Services**	401,350	311,959	255,826	969,135		969,135	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	369,267	2,924		372,191		372,191	6
7	Activities and Social Services	23,570		11,642	35,212		35,212	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	392,837	2,924	11,642	407,403		407,403	9
	C. General Administration							
10	Administrative and Clerical	402,938	36,612	52,224	491,774		491,774	10
11	Marketing Materials, Promotions and Advertising			20,963	20,963		20,963	11
12	Employee Benefits and Payroll Taxes			172,495	172,495		172,495	12
13	Insurance-Property, Liability and Malpractice			73,389	73,389		73,389	13
14	Other (specify):			738,215	738,215		738,215	14
15	**TOTAL General Administration**	402,938	36,612	1,057,286	1,496,836		1,496,836	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,197,125	351,495	1,324,754	2,873,374		2,873,374	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			859,189	859,189		859,189	17
18	Interest			669,125	669,125		669,125	18
19	Real Estate Taxes			78,269	78,269		78,269	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			88,048	88,048		88,048	22
23	**TOTAL Ownership**			1,694,631	1,694,631		1,694,631	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,197,125	351,495	3,019,385	4,568,005		4,568,005	24

Facility Name: Eden South Shore Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 28,83	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	15	12.69	3
4	Activity Director & Assistants	1	12.50	4
5	Social Service Workers			5
6	Head Cook	1	16.82	6
7	Cook Helpers/Assistants	12	12.18	7
8	Dishwashers	1	12.00	8
9	Maintenance Workers	2	19.01	9
10	Housekeepers	4	12.00	10
11	Laundry			11
12	Managers	2	18.31	12
13	Other Administrative	1	36.05	13
14	Clerical	4	12.68	14
15	Marketing	1	26.00	15
16	Other			16
17	Total (lines 1 thru 16)	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	Affiliate Asset management fees		40	$ 79,904	1
2					2
3					3
4					4
5					5
			Total	$ 79904	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 Fox Valley	North Aurora, IL			
Eden Supportive Living Champaign	Champaign, IL			
Eve Assisted Living	Hinsdale, IL			
Eden Supportive Living Chicago	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 [ ] 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 South Shore Report Period Beginning: 1/1/18 Ending: 12/31/18

VIII. OWNERSHIP COSTS

A. Purchase price of land 247,600 Year land was acquired 2005

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	140			2017	$ 19,440,564	$ 812,120	7 to 40	$ 812,120	$	$ 980,919	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Carpeting			2018	14,865	372	5	372		372	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)				$ 19,455,429	$ 812,492		$ 812,492	$	$ 981,291	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	$ 334,272	$ 46,697	$ 46,697	$	7 to 10	$ 58,371	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 334,272	$ 46,697	$ 46,697	$		$ 58,371	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 South Shore Report Period Beginning: 1/1/18 Ending: 12/31/18

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	Lakeside Bank		X	Acquisition/construction	10/14/15	$ 15,760,000	$ 15,331,691	10/28/22	4.2500	$ 669,125	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 15,760,000	$ 15,331,691			$ 669,125	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 15,760,000	$ 15,331,691			$ 669,125	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 South Shore **Report Period Beginning:** 1/1/18 **Ending:** 12/31/18

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 508,716	$	1
2	Cash-Patient Deposits	27,534		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 720,400)	1,462,682		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	145		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)**	$ 1,999,077	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	247,600		13
14	Buildings, at Historical Cost	19,455,429		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	334,272		16
17	Accumulated Depreciation (book methods)	(1,039,662)		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):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 18,997,639	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 20,996,716	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 46,343	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,309		28
29	Short-Term Notes Payable	750,000		29
30	Accrued Salaries Payable	16,927		30
31	Accrued Taxes Payable	39,700		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 883,279	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	15,035,516		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 15,035,516	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 15,918,795	$	45
46	**TOTAL EQUITY**	$ 5,077,921	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 20,996,716	$	47

***(See instructions.)**

Facility Name: Eden South Shore Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 3,949,369	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 3,949,369	3
	B. Other Operating Revenue		
4	Special Services	22,873	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)**	$ 22,873	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	43	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 43	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)**	$ 3,972,285	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	969,135	19
20	Health Care/ Personal Care	407,403	20
21	General Administration	1,496,836	21
	B. Capital Expense		
22	Ownership	1,694,631	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)**	$ 4,568,005	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (595,720)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (595,720)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 3,086,807	32
33	Private Pay - Net Inpatient Revenue	862,562	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 3,949,369	37

ENT 1 PART IV, LINE 14, COLUMN 3 - OTHER GENERAL ADMINISTRATION

accounting fees	$ 2,985
	$ 720,400
eous taxes and licenses	14,830
	$ 738,215

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

nagement fees	$ 79,904
tion expense	8,144
	$ 88,048