	FOR BHF USE						

LL2

Supportive Living Facility

2020

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2020)

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: 1000049

Facility Name: Eden Supportive Lvg Champaig

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

County: Champaign

Telephone Number: (217) 906-5900 **Fax #** (217) 378-6829

Federal Employer ID Number: ____________

Date Current Owners were Certified: 10/31/14

Type of Ownership:

VOLUNTARY, NON-PROFIT		PROPRIETARY		GOVERNMENTAL	
[ ]	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: ____________ Telephone Number: ( ) ____________
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 1/1/2020 to 12/31/2020 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., 232 S. Batavia Avenue, 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 Champaig Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units 12/31/2020

	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	150	Single Unit Apartment	150	54,750	1
2		Double Unit Apartment			2
3		Other			3
4	150	TOTALS	150	54,750	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	45,111	732		45,843	5
6	Double Unit					6
7	Other					7
8	TOTALS	45,111	732		45,843	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 83.73%

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 [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/20 Fiscal Year: 12/31/20
* 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 Supportive Lvg Champaig Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclassifications and Adjustments 5	Adjusted Total 6	
	A. General Services							
1	Dietary and Food Purchase	295,252	321,189		616,441		616,441	1
2	Housekeeping, Laundry and Maintenance	239,794	48,211	115,463	403,468		403,468	2
3	Heat and Other Utilities			175,374	175,374		175,374	3
4	Other (specify):							4
5	**TOTAL General Services**	535,046	369,400	290,837	1,195,283		1,195,283	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	395,092	6,061		401,153		401,153	6
7	Activities and Social Services	69,722		18,494	88,216		88,216	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	464,814	6,061	18,494	489,369		489,369	9
	C. General Administration							
10	Administrative and Clerical	403,514	42,042	87,954	533,510		533,510	10
11	Marketing Materials, Promotions and Advertising			6,708	6,708		6,708	11
12	Employee Benefits and Payroll Taxes			109,287	109,287		109,287	12
13	Insurance-Property, Liability and Malpractice			112,628	112,628		112,628	13
14	Other (specify): See Statement 1			1,975,000	1,975,000		1,975,000	14
15	**TOTAL General Administration**	403,514	42,042	2,291,577	2,737,133		2,737,133	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,403,374	417,503	2,600,908	4,421,785		4,421,785	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			545,473	545,473		545,473	17
18	Interest			494,872	494,872		494,872	18
19	Real Estate Taxes			119,888	119,888		119,888	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): See Statement 1			181,344	181,344		181,344	22
23	**TOTAL Ownership**			1,341,577	1,341,577		1,341,577	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,403,374	417,503	3,942,485	5,763,362		5,763,362	24

Facility Name: Eden Supportive Lvg Champaig

Report Period Beginning 1/1/2020 Ending: 12/31/2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 36.06	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	11	15.77	3
4	Activity Director & Assistants	2	15.54	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	12	12.53	7
8	Dishwashers	3	11.00	8
9	Maintenance Workers	3	16.99	9
10	Housekeepers	3	12.75	10
11	Laundry	2	13.75	11
12	Managers	6	25.95	12
13	Other Administrative			13
14	Clerical	5	13.22	14
15	Marketing	1	16.47	15
16	Other			16
17	Total (lines 1 thru 16)	49	$	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	$ 131,943	1
2					2
3					3
4					4
5					5
			Total	$ 131943	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

Name 1	City 2
Eden Supportive Living - Chicago	Chicago, IL
Eve Assisted Living	Hinsdale, IL
Eden Fox Valley	North Aurora, IL
Eden Supportive Living - South Shore	Chicago IL

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5

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 Champaig | Report Period Beginning: 1/1/2020 | Ending: 12/31/2020

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	$ 20,682,670	$ 524,112	15-40	$ 524,112	$	$ 4,418,799	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Flooring			2016	10,223	1,461	7	1,461		6,573	6
7	Waterfall			2016	4,112	588	7	588		2,645	7
8	Flooring			2017	3,021	432	7	432		1,349	8
9	Flooring			2018	4,022	575	7	575		1,437	9
10	Flooring			2018	3,456	494	7	494		1,235	10
11	Windows			2019	40,736	1,018	40	1,018		1,697	11
12	HVAC			2020	31,541		40				12
13	Windows			2020	9,324		40				13
14	Signs			2020	35,112	1,169	15	1,169		1,169	14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 20,824,217	$ 529,849		$ 529,849	$	$ 4,434,904	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	$ 775,787	$ 15,624	$ 15,624	$	5	$ 740,173	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 775,787	$ 15,624	$ 15,624	$		$ 740,173	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 Champaig   Report Period Beginning: 1/1/2020   Ending: 2/31/2020

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	NO	3 Purpose of Loan	4 Date of Note	Amount of Note Original	6 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	$ 13,069,256	8/1/53	3.7600	$ 494,872	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 14,203,987	$ 13,069,256			$ 494,872	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 14,203,987	$ 13,069,256			$ 494,872	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 Champaig   Report Period Beginning: 1/1/2020   Ending: 12/31/2020

XI. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,492,028	$	1
2	Cash-Patient Deposits	16,893		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 1,975,000)	1,064,979		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,988		6
7	Other Prepaid Expenses	18,573		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,623,461	$	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	20,824,217		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	775,787		16
17	Accumulated Depreciation (book methods)	(5,175,077)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	725,464		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 17,490,391	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 24,113,852	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 88,386	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,711		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	107,700		31
32	Accrued Interest Payable	40,950		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Current portion of mortgage payable	207,560		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 464,307	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	12,484,746		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Deferred development fee	2,250,000		42
43	Paycheck protection program loan	287,500		43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 15,022,246	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 15,486,553	$	45
46	**TOTAL EQUITY**	$ 8,627,299	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 24,113,852	$	47

*(See instructions.)

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	$ 5,247,343	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 5,247,343	3
	B. Other Operating Revenue		
4	Special Services	7,922	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)**	$ 7,922	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	944	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 944	14
	D. Other Revenue (specify):		
15	**COVID-19 Relief Funding**	150,379	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 150,379	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 5,406,588	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	1,195,283	19
20	Health Care/ Personal Care	489,369	20
21	General Administration	2,737,133	21
	B. Capital Expense		
22	Ownership	1,341,577	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)**	$ 5,763,362	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (356,774)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (356,774)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 1,089,768	32
33	Private Pay - Net Inpatient Revenue	4,157,575	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 5,247,343	37

Eden Supportive Living of Champaign
01/01/2020 to 12/31/2020

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

Bad debt	$ 1,975,000

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

Mortgage insurance premium	$ 37,967
Asset management fees	131,943
Amortization expense	11,423
Miscellaneous financial	11
	$ 181,344