FOR BHF USE

LL2

Supportive Living Facility

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2014)

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: 1000102

Facility Name: Eden Supportive Lvg N Aurora

Address: 311 S Lincolnway (Number) North Aurora (City) 60542 (Zip Code)

County: Kane

Telephone Number: (630) 929-3333 **Fax #** (630) 896-5894

Federal Employer ID Number:

Date Current Owners were Certified: 08/06/08

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 _____ to _____ 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., 12 W. Wilson St., 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 N Aurora Report Period Beginning: Ending:

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	144	Single Unit Apartment	144	54,292	1
2	6	Double Unit Apartment	6	4,380	2
3		Other			3
4	150	TOTALS	150	58,672	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	52,832	1,095		53,927	5
6	Double Unit	4,260			4,260	6
7	Other					7
8	TOTALS	57,092	1,095		58,187	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.17%

D. Indicate the number of paid bed-hold days the SLF had during this year 443 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 371 **(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: 12/31/14 Fiscal Year: 12/31/14

* 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 N Aurora **Report Period Beginning:** **Ending:**

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	328,544	380,590		709,134		709,134	1
2	Housekeeping, Laundry and Maintenance	230,568	35,151	174,309	440,028		440,028	2
3	Heat and Other Utilities			303,334	303,334		303,334	3
4	Other (specify):							4
5	**TOTAL General Services**	559,112	415,741	477,643	1,452,496		1,452,496	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	335,567	6,284		341,851		341,851	6
7	Activities and Social Services	35,000	3,668	31,973	70,641		70,641	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	370,567	9,952	31,973	412,492		412,492	9
	C. General Administration							
10	Administrative and Clerical	430,849	22,058	71,124	524,031		524,031	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			238,496	238,496		238,496	12
13	Insurance-Property, Liability and Malpractice			45,374	45,374		45,374	13
14	Other (specify):							14
15	**TOTAL General Administration**	430,849	22,058	354,994	807,901		807,901	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,360,528	447,751	864,610	2,672,889		2,672,889	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			379,515	379,515		379,515	17
18	Interest			362,854	362,854		362,854	18
19	Real Estate Taxes			176,331	176,331		176,331	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): See Statement 1			59,541	59,541		59,541	22
23	**TOTAL Ownership**			978,241	978,241		978,241	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,360,528	447,751	1,842,851	3,651,130		3,651,130	24

Facility Name: Eden Supportive Lvg N Aurora Report Period Beginning Ending:

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 31.73	1
2	Licensed Practical Nurses	1	21.35	2
3	Certified Nurse Assistants	8	9.50	3
4	Activity Director & Assistants	2	15.56	4
5	Social Service Workers			5
6	Head Cook	3	13.50	6
7	Cook Helpers/Assistants	7	10.43	7
8	Dishwashers	1	8.25	8
9	Maintenance Workers	3	12.62	9
10	Housekeepers	4	9.50	10
11	Laundry	1	12.00	11
12	Managers	4	25.78	12
13	Other Administrative	4	10.75	13
14	Clerical			14
15	Marketing	1	24.00	15
16	Other			16
17	Total (lines 1 thru 16)	40	$ 15.77	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 2014			$	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
Eden Supportive Living-Champaign	Champaign, IL			Supportive Living
Eve Assisted Living	Hinsdale, IL			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 [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 N Aurora **Report Period Beginning:** **Ending:**

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	$	$ 1,496,742	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Rehab and construction		2006	2007-2008	2,052,059		5			2,052,059	6
7	Rehab and construction		2006	2007-2008	411,673	58,828	7	58,828		382,279	7
8	Rehab and construction		2006	2007-2008	900,585	60,069	15	60,069		390,403	8
9	Rehab and construction		2009	2009	7,400	269	28	269		1,580	9
10	Rehab and construction		2010	2010	49,616	1,804	28	1,804		8,945	10
11	Rehab and construction		2011	2011	2,510	91	28	91		322	11
12	Rehab and construction		2012	2012	13,609	495	28	495		1,464	12
13	Rehab and construction		2014	2014	8,408	841	5	841		841	13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 9,902,907	$ 357,175		$ 357,175	$	$ 4,334,635	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	$ 161,047	$ 22,340	$ 22,340	$	5 to 7	$ 89,640	18
19	Vehicles	19,172				5	19,172	19
20	TOTAL (lines 18 and 19)	$ 180,219	$ 22,340	$ 22,340	$		$ 108,812	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:** **Ending:**

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: n/a

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	Hsng and Healthcare Fin.		X	Acquisition/construction/rehab/refi	6/15/12	$ 11,344,500	$ 10,910,920	7/1/47	3.3000	$ 362,854	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 11,344,500	$ 10,910,920			$ 362,854	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 11,344,500	$ 10,910,920			$ 362,854	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:** **Ending:**

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** _____ **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,076,413	$	1
2	Cash-Patient Deposits	139,128		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance none)	1,378,915		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,892		6
7	Other Prepaid Expenses	27,218		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,640,566	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	430,771		13
14	Buildings, at Historical Cost	9,902,907		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	180,219		16
17	Accumulated Depreciation (book methods)	(4,443,447)		17
18	Deferred Charges	150,515		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	419,233		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,640,198	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,280,764	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 124,063	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	134,958		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,989		30
31	Accrued Taxes Payable	168,000		31
32	Accrued Interest Payable	30,005		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Current portion of mortgage payable	189,761		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 673,776	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	10,721,159		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)**	$ 10,721,159	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 11,394,935	$	45
46	**TOTAL EQUITY**	$ (1,114,171)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 10,280,764	$	47

***(See instructions.)**

Facility Name: Eden Supportive Lvg N Aurora **Report Period Beginning:** **Ending:**

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	$ 5,680,558	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 5,680,558	3
	B. Other Operating Revenue		
4	Special Services	15,687	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)**	$ 15,687	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	365	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 365	14
	D. Other Revenue (specify):		
15	**Commercial rents**	13,200	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 13,200	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 5,709,810	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	1,452,496	19
20	Health Care/ Personal Care	412,492	20
21	General Administration	807,901	21
	B. Capital Expense		
22	Ownership	978,241	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)**	$ 3,651,130	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 2,058,680	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 2,058,680	31

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

insurance premium	$ 54,898
tion expense	4,643
	$ 59,541