

		FOR BHF USE			

LL2

Supportive Living Facility
2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2005)

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>I.</p> <p>Facility Name: <u>Eden Supportive Living</u></p> <p>Address: <u>940 West Gordon Terrace</u> <u>Chicago</u> <u>60613</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: (<u>773</u>) <u>472-1020</u> Fax # <u>773</u>)<u>472-1907</u></p> <p>Federal Employer ID Number: <u>47-0920387</u></p> <p>Date Current Owners were Certified: <u>May 1, 2005</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input 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>IRS Exemption Code _____</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>In the event there are further questions about this report, please contact: Name: <u>Mitch Hamblet</u> Telephone Number: (<u>773</u>) <u>472-1020</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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	IRS Exemption Code _____	<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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>5/10/05</u> to <u>12/31/05</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 border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mitch Hamblet</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>General Partner</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td><u>7/27/2006</u></td> </tr> <tr> <td>(Print Name and Title) <u>Paul H. Wieland</u> <u>CPA</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>Wieland & Company, Inc.</u> <u>235 E. Wilson St., Batavia, IL 60510</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(630)) 761-8199</u> Fax # <u>(630) 761-8299</u></td> <td></td> </tr> </table> <p align="center">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>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mitch Hamblet</u>			(Title) <u>General Partner</u>		Paid Preparer	(Signed) _____	<u>7/27/2006</u>	(Print Name and Title) <u>Paul H. Wieland</u> <u>CPA</u>	(Date) _____	(Firm Name & Address) <u>Wieland & Company, Inc.</u> <u>235 E. Wilson St., Batavia, IL 60510</u>		(Telephone) <u>(630)) 761-8199</u> Fax # <u>(630) 761-8299</u>	
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Facility Name Eden Supportive Living

Report Period Beginning: 5/10/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units 135/236/236

	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	33	Single Unit Apartment	33	7,788	1
2	51	Double Unit Apartment	51	12,036	2
3		Other		12,036	3
4	84	TOTALS	84	31,860	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	4,590	184		4,774	5
6	Double Unit	16,061			16,061	6
7	Other					7
8	TOTALS	20,651	184		20,835	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 65.40%

D. Indicate the number of paid bed-hold days the SLF had during this year 370 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 297 (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

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* 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 Living

Report Period Beginning:

5/10/05

Ending:

12/31/05

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5 (See Attached)	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	120,768	117,063	720	238,551	(192)	238,359	1
2	Housekeeping, Laundry and Maintenance	32,673	20,917	36,040	89,630		89,630	2
3	Heat and Other Utilities			68,817	68,817		68,817	3
4	Other (specify): Waste 3,572, Security 6,336			9,908	9,908		9,908	4
5	TOTAL General Services	153,441	137,980	115,485	406,906	(192)	406,714	5
B. Health Care and Programs								
6	Health Care/ Personal Care	126,868	11,396		138,264		138,264	6
7	Activities and Social Services		5,543		5,543		5,543	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	126,868	16,939		143,807		143,807	9
C. General Administration								
10	Administrative and Clerical	177,174	9,362	21,859	208,395	(2,832)	205,563	10
11	Marketing Materials, Promotions and Advertising		2,631	15,248	17,880		17,880	11
12	Employee Benefits and Payroll Taxes			86,969	86,969		86,969	12
13	Insurance-Property, Liability and Malpractice			46,790	46,790		46,790	13
14	Other (specify): Member contract fees			90,140	90,140		90,140	14
15	TOTAL General Administration	177,174	11,993	261,007	450,174	(2,832)	447,342	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	457,483	166,913	376,492	1,000,887	(3,024)	997,863	16
Capital Expenses								
D. Ownership								
17	Depreciation (Related party ownership)					201,057	201,057	17
18	Interest			291,012	291,012		291,012	18
19	Real Estate Taxes			18,730	18,730		18,730	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): MIP 31,333; Prin 41,807;RR 36,444			109,584	109,584	(78,251)	31,333	22
23	TOTAL Ownership			419,326	419,326	122,806	542,132	23
24	GRAND TOTAL (Sum of lines 16 and 23)	457,483	166,913	795,818	1,420,214	119,782	1,539,995	24

Facility Name: Eden Supportive Living

Report Period Beginning: 5/10/05 Ending: 12/31/05

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 31.25	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	18	9.00	3
4	Activity Director & Assistants	1	13.46	4
5	Social Service Workers			5
6	Head Cook	1	12.98	6
7	Cook Helpers/Assistants	8	10.00	7
8	Dishwashers	2	6.50	8
9	Maintenance Workers	1	12.50	9
10	Housekeepers	3	7.00	10
11	Laundry	1	7.00	11
12	Managers	1	38.46	12
13	Other Administrative	5	12.00	13
14	Clerical	1	19.23	14
15	Marketing	1	16.83	15
16	Other			16
17	Total (lines 1 thru 16)	44	\$	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	Maika Hamblet Admin	80%	40	\$ 90,000	1
2					2
3					3
4					4
5					5
Total				\$ 90000	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 <u>1</u>	City <u>2</u>

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
4131 Sheridan Properties, Ltd.	Chicago	Bldg owner

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). SEE ATTACHMENT

Facility Name: Eden Supportive Living

Report Period Beginning: 5/10/05

Ending: 12/31/05

VIII. OWNERSHIP COSTS (Owned by related entity)

A. Purchase price of land 189,617 Year land was acquired 2000

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	84		2000		\$ 1,155,432	\$ 42,016	30	\$ 38,514	\$ (3,502)	\$ 222,545	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Building rehabilitation		5/15/2005	7,279,839	151,663	30	151,663		151,663	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)				\$ 8,435,271	\$ 193,679		\$ 190,177	\$ (3,502)	\$ 374,208	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	\$ 152,323	5/15/2005	\$ 10,880	10,880	\$	15	\$ 10,880	18
19	Vehicles								19
20	TOTAL (lines 18 and 19)		\$ 152,323	\$ 10,880	\$ 10,880	\$		\$ 10,880	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	Other costs 2005	\$ 418,413	\$ \$ -	\$ \$ -	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)		\$ 418,413	\$	24

Facility Name: Eden Supportive Living

Report Period Beginning: 5/10/05

Ending: 12/31/05

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: 4131 Sheridan Properties, Ltd. (RELATED ENTITY)

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	2000	84	5/11/99	\$ 600,000	Actual costs until 1/1/06	3
4	Additions	2005		5/11/99		Rents begin 1/1/06	4
5			/ /				5
6			/ /				6
7	TOTAL		84		\$ 600,000		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	2	3	4	6	7	8	9		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related Long-Term									
1	HUD backed mortgage		x	Rehab	11/25/03	\$ 9,400,000	\$ 9,400,000	11/25/43	Var.	\$ 291,012
2	(final not closed yet)				/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 9,400,000	\$ 9,400,000			\$ 291,012
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 9,400,000	\$ 9,400,000			\$ 291,012

* 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.

STATE OF ILLINOIS

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Facility Name: **Eden Supportive Living**Report Period Beginning: **5/10/05**

Ending:

12/31/05**12/31/05****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/05**

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 463,610	\$ 463,610	1
2	Cash-Patient Deposits	100,962	100,962	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	583,300	583,300	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			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)	\$ 1,147,872	\$ 1,147,872	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,147,872	\$ 1,147,872	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 23,185	\$ 23,185	26
27	Officer's Accounts Payable	158,328	158,328	27
28	Accounts Payable-Patient Deposits	90,540	90,540	28
29	Short-Term Notes Payable	460,806	460,806	29
30	Accrued Salaries Payable	51,501	51,501	30
31	Accrued Taxes Payable			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)	\$ 784,360	\$ 784,360	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable			38
39	Mortgage Payable			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)	\$	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 784,360	\$ 784,360	45
46	TOTAL EQUITY	\$ 363,512	\$ 363,512	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,147,872	\$ 1,147,872	47

*(See instructions.)

Facility Name: Eden Supportive Living

Report Period Beginning: 5/10/05

Ending:

12/31/05

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,682,160	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,682,160	3
B. Other Operating Revenue			
4	Special Services	64,930	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	192	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 65,122	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15			15
16	Commerical stores	36,277	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 36,277	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,783,559	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	406,906	19
20	Health Care/ Personal Care	143,807	20
21	General Administration	450,174	21
B. Capital Expense			
22	Ownership	419,326	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)	\$ 1,420,213	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 363,346	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 363,346	31

SCHEDULE IV, LINE 1, COLUMN 5 - Dietary and food adjustments

Reduction for vending machine costs (192)

SCHEDULE IV, LINE 10, COLUMN 5 - Administrative and clerical adjustments

Reduction for travel and entertainment costs (1,610)

Reduction for fines (285)

Reduction for overdraft charges (937)

Total reductions (2,832)

SCHEDULE IV, LINE 17, COLUMN 5 - Depreciation adjustment

Increase for depreciation - see Table VIII

Property owned by related entity 201,057

SCHEDULE IV, LINE 22, COLUMN 5 - Ownership expenses adjustment

Reductions for amounts paid on behalf of related ownership entity -

Replacement reserve deposits (36,444)

Principal payments (41,807)

(78,251)