

		FOR BHF USE			

LL2

Supportive Living Facility

**2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2008)**

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 Name: Eden Supportive Living

Address: 940 W Gordon Terrace Chicago 60613
Number City Zip Code

County: Cook

Telephone Number: (773) 472-1020 Fax # 773 572-6498

Federal Employer ID Number: 47-0920387

Date Current Owners were Certified: 5/10/05 (incorporated)

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> I believe it is Inc. 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 checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Mitch Hamblet Telephone Number: (630-929-3333
Email Address: mhamblet@edensupportiveliving.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/08 to 12/31/08 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) _____	4/30/2009
	(Type or Print Name) <u>Michael J. Hamblet, Jr.</u>	(Date)
	(Title) <u>Managing Member</u>	
Paid Preparer	(Signed) _____	4/30/2009
	(Print Name and Title) <u>Paul H. Wieland</u> <u>President</u>	(Date)
	(Firm Name & Address) <u>Wieland & Co., Inc., 12 W. Wilson St.</u> <u>Suite 2A, Batavia, IL 60510</u>	
	(Telephone) <u>(630) 406-4490</u> Fax <u>(630) 406-4491</u>	

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 Living

Report Period Beginning: 1/1/2008 Ending: #####

III. STATISTICAL DATA

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

Date of change in certified units / /

	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	12,078	1
2	51	Double Unit Apartment	51	18,666	2
3		Other			3
4	84	TOTALS	84	30,744	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	8,418	1,464		9,882	5
6	Double Unit	19,136			19,136	6
7	Other					7
8	TOTALS	27,554	1,464		29,018	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 94.39%

D. Indicate the number of paid bed-hold days the SLF had during this year 1,555 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 92 **(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

ACCRUAL MODIFIED CASH* CASH*

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

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

* 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:

1/1/2008

Ending: 12/31/2008

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
	A. General Services							
1	Dietary and Food Purchase	290,106	278,250	497	568,853		568,853	1
2	Housekeeping, Laundry and Maintenance	155,231	56,354	183,150	394,735		394,735	2
3	Heat and Other Utilities			178,047	178,047		178,047	3
4	Other (specify):							4
5	TOTAL General Services	445,337	334,604	361,694	1,141,635		1,141,635	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	300,297	4,082		304,379		304,379	6
7	Activities and Social Services			27,486	27,486		27,486	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	300,297	4,082	27,486	331,865		331,865	9
	C. General Administration							
10	Administrative and Clerical	220,825	2,984	28,294	252,103		252,103	10
11	Marketing Materials, Promotions and Advertising			41,512	41,512		41,512	11
12	Employee Benefits and Payroll Taxes			218,642	218,642		218,642	12
13	Insurance-Property, Liability and Malpractice			79,003	79,003		79,003	13
14	Other (specify):Statement 1)			67,355	67,355		67,355	14
15	TOTAL General Administration	220,825	2,984	434,806	658,615		658,615	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	966,459	341,670	823,986	2,132,115		2,132,115	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			250,014	250,014		250,014	17
18	Interest			524,942	524,942		524,942	18
19	Real Estate Taxes			73,820	73,820		73,820	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):Statement 2)			140,587	140,587		140,587	22
23	TOTAL Ownership			989,363	989,363		989,363	23
24	GRAND TOTAL (Sum of lines 16 and 23)	966,459	341,670	1,813,349	3,121,478		3,121,478	24

Facility Name: **Eden Supportive Living**

Report Period Beginning: **1/1/2008** Ending: **12/31/2008**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	4	\$ 37.07	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	23	9.00	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	5	10.50	6
7	Cook Helpers/Assistants	31	8.00	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers	8	22.00	12
13	Other Administrative			13
14	Clerical			14
15	Marketing	3	16.00	15
16	Other			16
17	Total (lines 1 thru 16)	74	\$	17

Equals number of employees in each category for whole yr.

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 Fox Valley		Aurora, 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
 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).

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 IN 2008			\$	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

Facility Name: Eden Supportive Living

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

VIII. OWNERSHIP COSTS

A. Purchase price of land 189,617 Year land was acquired 1999

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			1999	2005	\$ 8,039,286	\$ 249,306	40	\$ 249,306	\$	\$ 1,005,232	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Cardio room mirrors		2008		1,850	220	7	220		220	6
7	Office buildout		2008		4,600	153	28	153		153	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)				\$ 8,045,736	\$ 249,679		\$ 249,679	\$	\$ 1,005,605	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	\$ 187,783	\$ 35,533	\$ 35,533	\$	5-7	\$ 123,626	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 187,783	\$ 35,533	\$ 35,533	\$		\$ 123,626	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 Living

Report Period Beginning: 1/1/2008

Ending: 12/31/ 12/31/2008

IX. RENTAL COSTS N/A

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	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		/ /	\$			3
4	Additions		/ /				4
5			/ /				5
6			/ /				6
7	TOTAL			\$			7

8. Is movable equipment rental included in building rental? YES NO

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	
		Related**				Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1	MMA MORT INV CORP		X	Rehab and SLF conversion	11/25/03	\$ 9,400,000	\$ 9,138,866	2/21/45	5.7200	\$ 524,942	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 9,400,000	\$ 9,138,866			\$ 524,942	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 9,400,000	\$ 9,138,866			\$ 524,942	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 Living**Report Period Beginning: **1/1/2008**Ending: **12/31/2008****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/08**

(last day of reporting year)

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 596,540	\$ 596,540	1
2 Cash-Patient Deposits	104,797	104,797	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 10,400)	997,043	997,043	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	26,449	26,449	6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,724,829	\$ 1,724,829	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	189,617	189,617	13
14 Buildings, at Historical Cost	8,045,736	8,045,736	14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	187,783	187,783	16
17 Accumulated Depreciation (book methods)	(1,129,231)	(1,129,231)	17
18 Deferred Charges	782,158	782,158	18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds	247,898	247,898	21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,323,961	\$ 8,323,961	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,048,790	\$ 10,048,790	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 36,781	\$ 36,781	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	104,797	104,797	28
29 Short-Term Notes Payable	78,050	78,050	29
30 Accrued Salaries Payable	29,709	29,709	30
31 Accrued Taxes Payable	78,400	78,400	31
32 Accrued Interest Payable	43,562	43,562	32
33 Deferred Compensation			33
34 Federal and State Income Taxes			34
Other Current Liabilities(specify):			
35 Deferred revenue	3,500	3,500	35
36			36
TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 374,799	\$ 374,799	37
D. Long-Term Liabilities			
38 Long-Term Notes Payable			38
39 Mortgage Payable	9,060,817	9,060,817	39
40 Bonds Payable			40
41 Deferred Compensation			41
Other Long-Term Liabilities(specify):			
42 Due to owners (from surplus cash)	708,351	708,351	42
43 Commercial security deposits	5,100	5,100	43
TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 9,774,268	\$ 9,774,268	44
TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,149,067	\$ 10,149,067	45
46 TOTAL EQUITY	\$ (100,277)	\$ (100,277)	46
TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,048,790	\$ 10,048,790	47

*(See instructions.)

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	\$ 3,825,866	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,825,866	3
B. Other Operating Revenue			
4	Special Services	61,937	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)	\$ 61,937	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	28,041	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 28,041	14
D. Other Revenue (specify):			
15	Commercial rents	38,250	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 38,250	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,954,094	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	1,141,635	19
20	Health Care/ Personal Care	331,865	20
21	General Administration	658,615	21
B. Capital Expense			
22	Ownership	989,363	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)	\$ 3,121,478	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 832,616	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 832,616	31

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

Renting expenses	\$ 19,621
Audit and accounting fees	7,500
Bookkeeping	9,059
Legal	2,558
Miscellaneous taxes and licenses	13,489
Other office and general costs	<u>15,128</u>
	<u>\$ 67,355</u>

STATEMENT 2 PART IV, LINE 22, COLUMN 3 - OTHER OWNERSHIP

Mortgage insurance premium	\$ 46,219
Miscellaneous financial	7,516
Amortization expense	<u>86,852</u>
	<u>\$140,587</u>