

Facility Name Eden Supportive Living

Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

Date of change in certified units 84/ 84 /365

	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	12,045	1
2	51	Double Unit Apartment	51	18,615	2
3		Other		18,615	3
4	84	TOTALS	84	49,275	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	11,172	608		11,780	5
6	Double Unit	17,443	457		17,900	6
7	Other	16,597			16,597	7
8	TOTALS	45,212	1,065		46,277	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.92%

D. Indicate the number of paid bed-hold days the SLF had during this year
612 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 278 (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: 12/31/10 Fiscal Year: 12/31/10

* 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. _____

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	312,430	299,641		612,071		612,071	1
2	Housekeeping, Laundry and Maintenance	237,865	72,043	64,067	373,975		373,975	2
3	Heat and Other Utilities			102,879	102,879		102,879	3
4	Other (specify):							4
5	TOTAL General Services	550,295	371,684	166,946	1,088,925		1,088,925	5
B. Health Care and Programs								
6	Health Care/ Personal Care	290,583	4,430		295,013		295,013	6
7	Activities and Social Services	59,280		42,920	102,200		102,200	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	349,863	4,430	42,920	397,213		397,213	9
C. General Administration								
10	Administrative and Clerical	260,571	21,485	14,621	296,677		296,677	10
11	Marketing Materials, Promotions and Advertising			9,673	9,673		9,673	11
12	Employee Benefits and Payroll Taxes			152,215	152,215		152,215	12
13	Insurance-Property, Liability and Malpractice			55,375	55,375		55,375	13
14	Other (specify): See Statement 1			68,155	68,155		68,155	14
15	TOTAL General Administration	260,571	21,485	300,039	582,095		582,095	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,160,729	397,599	509,905	2,068,233		2,068,233	16
Capital Expenses								
D. Ownership								
17	Depreciation			241,110	241,110		241,110	17
18	Interest			515,741	515,741		515,741	18
19	Real Estate Taxes			63,047	63,047		63,047	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): See Statement 2			131,933	131,933		131,933	22
23	TOTAL Ownership			951,831	951,831		951,831	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,160,729	397,599	1,461,736	3,020,064		3,020,064	24

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 26.44	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	12	9.78	3
4	Activity Director & Assistants	2	14.25	4
5	Social Service Workers			5
6	Head Cook	1	16.34	6
7	Cook Helpers/Assistants	12	9.07	7
8	Dishwashers	1	9.13	8
9	Maintenance Workers	2	12.50	9
10	Housekeepers	3	10.67	10
11	Laundry			11
12	Managers	4	26.80	12
13	Other Administrative			13
14	Clerical	7	11.77	14
15	Marketing	1	15.00	15
16	Other			16
17	Total (lines 1 thru 16)	46	\$ 12.35	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 in 2010			\$	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

Name <u>1</u>	City <u>2</u>
Eden Fox Valley	North Aurora, IL

OTHER RELATED BUSINESS ENTITIES

Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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).

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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	84		1999	2005	\$ 8,039,286	\$ 214,119	40	\$ 214,119	\$	\$ 1,433,459	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Cardio room mirrors	2008		1,850	264	7	264		584	6
7		Office buildout	2008		4,600	167	28	167		651	7
8		Hot water boiler	2009		5,818	831	7	831		900	8
9		Granite	2009		6,400	233	28	233		349	9
10		Hot water boiler	2010		5,818	831	7	831		831	10
11		Buildout/remodel	2010		7,407	112	28	112		112	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 8,071,179	\$ 216,557		\$ 216,557	\$	\$ 1,436,886	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	\$ 229,315	\$ 21,240	\$ 21,240	\$		\$ 182,723	18
19	Vehicles	16,567	3,313	3,313			5,798	19
20	TOTAL (lines 18 and 19)	\$ 245,882	\$ 24,553	\$ 24,553	\$		\$ 188,521	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

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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

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

	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	Oak Grove Capital		x	Rehab and SLF conversion	11/25/03	\$ 9,400,000	\$ 8,971,083	2/ 21 /45	5.7200	\$ 515,741	1
2					/ /			/ /			2
3					/ /			/ /			3
Working Capital											
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 9,400,000	\$ 8,971,083			\$ 515,741	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 9,400,000	\$ 8,971,083			\$ 515,741	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.

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12/31/10**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/10**

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,580,393	\$ 1,580,393	1
2	Cash-Patient Deposits	95,570	95,570	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance \$9,500)	263,672	263,672	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,737	23,737	6
7	Other Prepaid Expenses	20,692	20,692	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,984,064	\$ 1,984,064	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	8,071,179	8,071,179	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	245,882	245,882	16
17	Accumulated Depreciation (book methods)	(1,625,407)	(1,625,407)	17
18	Deferred Charges	608,454	608,454	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	346,156	346,156	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,835,881	\$ 7,835,881	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,819,945	\$ 9,819,945	25

*(See instructions.)

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 41,156	\$ 41,156	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	95,570	95,570	28
29	Short-Term Notes Payable-Current Mtg.			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	72,800	72,800	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Current portion of mortgage note	80,384	80,384	35
36	Deferred revenue	17,725	17,725	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 307,635	\$ 307,635	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,890,699	8,890,699	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Due to owners (from surplus cash)	630,814	630,814	42
43	Commercial security deposits	5,100	5,100	43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 9,526,613	\$ 9,526,613	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 9,834,248	\$ 9,834,248	45
46	TOTAL EQUITY	\$ (14,303)	\$ (14,303)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,819,945	\$ 9,819,945	47

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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	\$ 4,300,059	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 4,300,059	3
B. Other Operating Revenue			
4	Special Services	15,308	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
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 15,308	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	3,372	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 3,372	14
D. Other Revenue (specify):			
15	Commercial rents	23,961	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 23,961	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 4,342,700	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	1,088,925	19
20	Health Care/ Personal Care	397,213	20
21	General Administration	582,095	21
B. Capital Expense			
22	Ownership	951,831	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 3,020,064	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 1,322,636	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 1,322,636	31

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

expenses	\$ 3,071
accounting fees	13,400
ing/payroll processing	8,794
	12,153
eous taxes and licenses	5,688
	19,000
ce and general costs	<u>6,049</u>
	<u>\$ 68,155</u>

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

insurance premium	\$ 45,081
tion expense	<u>86,852</u>
	<u>\$131,933</u>