

		FOR BHF USE			

LL2

Supportive Living Facility

**2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2013)**

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. Facility ID Number: <u>1000102</u></p> <p>Facility Name: <u>Eden Supportive Lvg N Aurora</u></p> <p>Address: <u>311 South Lincolnway</u> <u>North Aurora</u> <u>60542</u> <small>Number City Zip Code</small></p> <p>County: <u>Kane</u></p> <p>Telephone Number: (<u>630</u>) <u>929-3333</u> Fax # (<u>630</u>) <u>896-5894</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>08/06/08</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" 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>630</u>) <u>929-3333</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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>01/01/2013</u> to <u>12/31/2013</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 style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Michael J. Hamblet, Jr.</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Managing Member</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Paul H. Wieland President</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Wieland & Company, Inc. 12 W. Wilson St., Batavia, IL 60510</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(630) 406-4490</u> Fax # (<u>630</u>) <u>406-4491</u></td> <td></td> </tr> </table> <p align="right">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>Michael J. Hamblet, Jr.</u>			(Title) <u>Managing Member</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Paul H. Wieland President</u>			(Firm Name & Address) <u>Wieland & Company, Inc. 12 W. Wilson St., Batavia, IL 60510</u>			(Telephone) <u>(630) 406-4490</u> Fax # (<u>630</u>) <u>406-4491</u>	
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Facility Name Eden Supportive Lvg N Aurora

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

Date of change in certified units 156/156/365

	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	144	Single Unit Apartment	144	52,560	1
2	6	Double Unit Apartment	6	2,190	2
3		Other			3
4	150	TOTALS	150	54,750	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	50,553	1,551		52,104	5
6	Double Unit	1,750			1,750	6
7	Other					7
8	TOTALS	52,303	1,551		53,854	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.36%

D. Indicate the number of paid bed-hold days the SLF had during this year 493 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 68 (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: 12/31/13 Fiscal Year: 12/31/13

* 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:

01/01/2013

Ending: 12/31/2013

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	345,644	384,702		730,346		730,346	1
2	Housekeeping, Laundry and Maintenance	248,069	65,201	172,993	486,263		486,263	2
3	Heat and Other Utilities			194,772	194,772		194,772	3
4	Other (specify):							4
5	TOTAL General Services	593,713	449,903	367,765	1,411,381		1,411,381	5
B. Health Care and Programs								
6	Health Care/ Personal Care	396,547	5,040		401,587		401,587	6
7	Activities and Social Services	67,558	4,105	33,714	105,377		105,377	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	464,105	9,145	33,714	506,964		506,964	9
C. General Administration								
10	Administrative and Clerical	287,624	10,710	52,954	351,288		351,288	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			256,323	256,323		256,323	12
13	Insurance-Property, Liability and Malpractice			45,482	45,482		45,482	13
14	Other (specify):							14
15	TOTAL General Administration	287,624	10,710	354,759	653,093		653,093	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,345,442	469,758	756,238	2,571,438		2,571,438	16
Capital Expenses								
D. Ownership								
17	Depreciation			581,037	581,037		581,037	17
18	Interest			368,823	368,823		368,823	18
19	Real Estate Taxes			161,683	161,683		161,683	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): See Statement 1			98,614	98,614		98,614	22
23	TOTAL Ownership			1,210,157	1,210,157		1,210,157	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,345,442	469,758	1,966,395	3,781,595		3,781,595	24

Facility Name: Eden Supportive Lvg N Aurora

Report Period Beginning 01/01/2013 Ending: 12/31/2013

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 32.47	1
2	Licensed Practical Nurses	1	22.40	2
3	Certified Nurse Assistants	19	11.02	3
4	Activity Director & Assistants	2	16.24	4
5	Social Service Workers			5
6	Head Cook	3	18.13	6
7	Cook Helpers/Assistants	18	11.11	7
8	Dishwashers	1	11.60	8
9	Maintenance Workers	4	18.95	9
10	Housekeepers	4	11.59	10
11	Laundry	1	12.76	11
12	Managers	2	36.06	12
13	Other Administrative	7	12.16	13
14	Clerical			14
15	Marketing	1	23.20	15
16	Other			16
17	Total (lines 1 thru 16)	64	\$ 237.69	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 2013			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

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	
Eden Supportive Living-Champaign		Champaign, IL	
Eve Assisted Living		Hinsdale, IL	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
				Supportive Living	
				Supportive Living	
				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

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).

Facility Name: Eden Supportive Lvg N Aurora

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	\$	\$ 1,261,964	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Rehab and construction		2006	2007-2008	2,052,059	205,205	5	205,205		2,052,059	6
7	Rehab and construction		2006	2007-2008	411,673	58,787	7	58,787		323,451	7
8	Rehab and construction		2006	2007-2008	900,585	60,069	15	60,069		330,334	8
9	Rehab and construction		2009	2009	7,400	269	28	269		1,311	9
10	Rehab and construction		2010	2010	49,616	1,804	28	1,804		7,141	10
11	Rehab and construction		2011	2011	2,510	91	28	91		231	11
12	Rehab and construction		2012	2012	13,609	495	28	495		969	12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 9,894,499	\$ 561,498		\$ 561,498	\$	\$ 3,977,460	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	\$ 144,294	\$ 18,004	\$ 18,004	\$	5 to 7	\$ 67,300	18
19	Vehicles	19,172	1,535	1,535		5	19,172	19
20	TOTAL (lines 18 and 19)		\$ 163,466	\$ 19,539	\$		\$ 86,472	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: 01/01/2013

Ending:

12/31/2013

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,543,540	\$	1
2	Cash-Patient Deposits	116,719		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>none</u>)	1,241,682		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	38,222		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,940,163	\$	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	9,894,499		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	163,466		16
17	Accumulated Depreciation (book methods)	(4,063,932)		17
18	Deferred Charges	155,158		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	347,056		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,927,018	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,867,181	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 74,594	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	115,842		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,136		30
31	Accrued Taxes Payable	151,703		31
32	Accrued Interest Payable	30,510		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Current portion of mortgage payable	183,610		35
36	Prepaid revenue	83,302		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 673,697	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	10,910,919		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)	\$ 10,910,919	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 11,584,616	\$	45
46	TOTAL EQUITY	\$ (717,435)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,867,181	\$	47

*(See instructions.)

Facility Name: Eden Supportive Lvg N Aurora

Report Period Beginning: 01/01/2013

Ending:

12/31/2013

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	\$ 5,520,882	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 5,520,882	3
B. Other Operating Revenue			
4	Special Services	6,626	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)	\$ 6,626	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	484	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 484	14
D. Other Revenue (specify):			
15	Commercial rents	23,277	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 23,277	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 5,551,269	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	1,411,381	19
20	Health Care/ Personal Care	506,964	20
21	General Administration	653,093	21
B. Capital Expense			
22	Ownership	1,210,157	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)	\$ 3,781,595	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 1,769,674	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 1,769,674	31

Eden Fox Valley
01/01/2013 to 12/31/2013

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

Mortgage insurance premium	\$ 93,855
Miscellaneous financial	116
Amortization expense	<u>4,643</u>
	<u>\$ 98,614</u>