

		FOR BHF USE			

LL2

Supportive Living Facility

**2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)**

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>1000146</u></p> <p>Facility Name: <u>Eden Supptive Lvg Champaign</u></p> <hr/> <p>Address: <u>222 North State St</u> <u>Champaign</u> <u>61820</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Champaign</u></p> <p>Telephone Number: (<u>217</u>) <u>903-5900</u> Fax # (<u>217</u>) <u>378-6829</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10/31/2014</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.</td> <td><input checked="" type="checkbox"/> PROPRIETARY Individual</td> <td><input type="checkbox"/> GOVERNMENTAL 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>312</u>) <u>263-7347</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.	<input checked="" type="checkbox"/> PROPRIETARY Individual	<input type="checkbox"/> GOVERNMENTAL 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>1/1/2016</u> to <u>12/31/2016</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></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>Paid Preparer</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. 201 Houston St., Suite 301, Batavia, IL 60510</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) (<u>630</u>) <u>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>			(Signed) _____	(Date) _____	Paid Preparer	(Print Name and Title) <u>Paul H. Wieland President</u>			(Firm Name & Address) <u>Wieland & Company, Inc. 201 Houston St., Suite 301, Batavia, IL 60510</u>			(Telephone) (<u>630</u>) <u>406-4490</u> Fax # (<u>630</u>) <u>406-4491</u>	
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Facility Name: Eden Supptive Lvg Champaign

Report Period Beginning:

1/1/2016

Ending: 12/31/2016

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	240,539	331,675		572,214		572,214	1
2	Housekeeping, Laundry and Maintenance	138,696	32,698	155,307	326,701		326,701	2
3	Heat and Other Utilities			104,483	104,483		104,483	3
4	Other (specify):							4
5	TOTAL General Services	379,235	364,373	259,790	1,003,398		1,003,398	5
B. Health Care and Programs								
6	Health Care/ Personal Care	350,407	1,960		352,367		352,367	6
7	Activities and Social Services	35,504		16,857	52,361		52,361	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	385,911	1,960	16,857	404,728		404,728	9
C. General Administration								
10	Administrative and Clerical	350,053	28,471	96,539	475,063		475,063	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			155,813	155,813		155,813	12
13	Insurance-Property, Liability and Malpractice			66,133	66,133		66,133	13
14	Other (specify):							14
15	TOTAL General Administration	350,053	28,471	318,485	697,009		697,009	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,115,199	394,804	595,132	2,105,135		2,105,135	16
Capital Expenses								
D. Ownership								
17	Depreciation			792,273	792,273		792,273	17
18	Interest			607,261	607,261		607,261	18
19	Real Estate Taxes			49,812	49,812		49,812	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			354,931	354,931		354,931	22
23	TOTAL Ownership			1,804,277	1,804,277		1,804,277	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,115,199	394,804	2,399,409	3,909,412		3,909,412	24

Facility Name: Eden Supptive Lvg Champaign

Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	10	\$ 11.27	3
4	Activity Director & Assistants	2	\$ 14.43	4
5	Social Service Workers			5
6	Head Cook	1	\$ 24.75	6
7	Cook Helpers/Assistants	5	\$ 10.12	7
8	Dishwashers			8
9	Maintenance Workers	2	\$ 12.84	9
10	Housekeepers	3	\$ 9.30	10
11	Laundry			11
12	Managers	4	\$ 23.57	12
13	Other Administrative			13
14	Clerical	3	\$ 11.66	14
15	Marketing	1	\$ 16.83	15
16	Other	3	\$ 9.81	16
17	Total (lines 1 thru 16)	35	\$ 15.55	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	Affiliate Asset Management fees		40	\$ 46,370	1
2					2
3					3
4					4
5					5
				Total	\$ 46370 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	City
Eden Supportive Living-Chicago	Chicago, IL
Eve Assisted Living	Hinsdale, IL
Eden Fox Valley	North Aurora, IL

OTHER RELATED BUSINESS ENTITIES

Name	City	Type of Business
		Supportive living
		Assisted living
		Supportive 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 Supptive Lvg Champaign

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VIII. OWNERSHIP COSTS

A. Purchase price of land 340,000 Year land was acquired 2013

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		2013	2013-2014	\$ 20,697,005	\$ 649,033	40	\$ 649,033	\$	\$ 2,106,560	1
2											2
3											3
4											4
5											5
Improvement Type											
6											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)				\$ 20,697,005	\$ 649,033		\$ 649,033	\$	\$ 2,106,560	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	\$ 720,386	\$ 143,240	\$ 143,240	\$	5	\$ 451,190	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 720,386	\$ 143,240	\$ 143,240	\$		\$ 451,190	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 Supptive Lvg Champaign

Report Period Beginning: 1/1/2016

Ending: 2/31/2016 12/31/2016

IX. RENTAL COSTS

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		
	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	Acquisition/construction/rehab	6/1/12	\$ 14,203,987	\$ 13,825,788	8/1/53	3.7600	\$ 522,835
2	2012B Bonds-surplus cash		X	Purchase money	6/1/12	1,000,000	928,815	4/1/29	9.0000	84,426
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 15,203,987	\$ 14,754,603			\$ 607,261
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 15,203,987	\$ 14,754,603			\$ 607,261

* 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 Supptive Lvg Champaign

Report Period Beginning: 1/1/2016

Ending:

12/31/2016

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 597,862	\$	1
2	Cash-Patient Deposits	16,394		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,069,690		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	60,832		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,744,778	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	340,000		13
14	Buildings, at Historical Cost	20,697,005		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	720,386		16
17	Accumulated Depreciation (book methods)	(2,557,750)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	284,539		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 19,484,180	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 22,228,958	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 54,067	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,545		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	25,286		30
31	Accrued Taxes Payable	50,900		31
32	Accrued Interest Payable	106,013		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Current portion of mortgage payable	178,620		35
36	Current portion of surplus cash note	40,467		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 469,898	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	888,348		38
39	Mortgage Payable	13,224,526		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Deferred developer fee	2,250,000		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 16,362,874	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 16,832,772	\$	45
46	TOTAL EQUITY	\$ 5,396,186	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 22,228,958	\$	47

*(See instructions.)

Facility Name: Eden Supptive Lvg Champaign

Report Period Beginning: 1/1/2016

Ending:

12/31/2016

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

		1	
I. Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 4,818,882	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,818,882	3
B. Other Operating Revenue			
4	Special Services	734	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)	\$ 734	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	29	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 29	14
D. Other Revenue (specify):			
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,819,645	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	1,003,398	19
20	Health Care/ Personal Care	404,728	20
21	General Administration	697,009	21
B. Capital Expense			
22	Ownership	1,804,277	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)	\$ 3,909,412	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 910,233	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 910,233	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 3,182,366	32
33	Private Pay - Net Inpatient Revenue	1,636,516	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 4,818,882	37

Eden Supportive Living of Champaign
01/01/2016 to 12/31/2016

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

Mortgage insurance premium	\$ 82,591
Miscellaneous financial expense	32
Entity expense - legal	214,515
Asset management fees	46,370
Amortization expense	<u>11,423</u>
	<u>\$ 354,931</u>