

		FOR BHF USE			

LL2

Supportive Living Facility

**2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)**

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>1000155</u></p> <p>Facility Name: <u>Eden South Shore</u></p> <hr/> <p>Address: <u>7200 S Dorchester</u> <u>Chicago</u> <u>60619</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: (<u>773</u>) <u>466-6868</u> Fax # (<u>773</u>) <u>466-6833</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>11/6/2017</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:</p> <p>Name: <u>Mitch Hamblet</u> Telephone Number: (<u>630</u>) <u>929-3333</u></p> <p>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>11/6/17</u> to <u>12/31/2017</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%; vertical-align: top;">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 style="vertical-align: top;">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. 201 Houston Street, Ste. 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>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Paul H. Wieland President</u>			(Firm Name & Address) <u>Wieland & Company, Inc. 201 Houston Street, Ste. 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 South Shore

Report Period Beginning: 11/6/17 Ending: 12/31/2017

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	130	Single Unit Apartment	7,280	7,280	1
2	10	Double Unit Apartment	560	560	2
3		Other			3
4	140	TOTALS	7,840	7,840	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	1,664			1,664	5
6	Double Unit					6
7	Other					7
8	TOTALS	1,664			1,664	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 21.22%

D. Indicate the number of paid bed-hold days the SLF had during this year

 Also, indicate the number of unpaid bed-hold days the SLF had during this year. (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: 12/31/17 Fiscal Year: 12/31/17

* 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 South Shore

Report Period Beginning:

11/6/17

Ending: 12/31/2017

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	20,460	38,917		59,377		59,377	1
2	Housekeeping, Laundry and Maintenance	14,506	13,278	12,465	40,249		40,249	2
3	Heat and Other Utilities			28,443	28,443		28,443	3
4	Other (specify):							4
5	TOTAL General Services	34,966	52,195	40,908	128,069		128,069	5
B. Health Care and Programs								
6	Health Care/ Personal Care	34,739	581		35,320		35,320	6
7	Activities and Social Services	4,294		324	4,618		4,618	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	39,033	581	324	39,938		39,938	9
C. General Administration								
10	Administrative and Clerical	134,897	16,179		151,076		151,076	10
11	Marketing Materials, Promotions and Advertising			957	957		957	11
12	Employee Benefits and Payroll Taxes			34,384	34,384		34,384	12
13	Insurance-Property, Liability and Malpractice			26,888	26,888		26,888	13
14	Other (specify):			48,029	48,029		48,029	14
15	TOTAL General Administration	134,897	16,179	110,258	261,334		261,334	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	208,896	68,955	151,490	429,341		429,341	16
Capital Expenses								
D. Ownership								
17	Depreciation			34,743	34,743		34,743	17
18	Interest			176,483	176,483		176,483	18
19	Real Estate Taxes			6,988	6,988		6,988	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			218,214	218,214		218,214	23
24	GRAND TOTAL (Sum of lines 16 and 23)	208,896	68,955	369,704	647,555		647,555	24

Facility Name: Eden South Shore

Report Period Beginning: 11/6/17 Ending: 12/31/2017

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	8	11.00	3
4	Activity Director & Assistants	1	16.90	4
5	Social Service Workers			5
6	Head Cook	1	16.82	6
7	Cook Helpers/Assistants	5	11.50	7
8	Dishwashers			8
9	Maintenance Workers	1	11.00	9
10	Housekeepers	1	11.00	10
11	Laundry			11
12	Managers	3	25.00	12
13	Other Administrative			13
14	Clerical	3	12.00	14
15	Marketing	1	26.43	15
16	Other			16
17	Total (lines 1 thru 16)	25	\$ 17.29	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	\$ 9,164	1
2					2
3					3
4					4
5					5
				Total	\$ 9164 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	1	City	2
Eden Fox Valley		North Aurora, IL	
Eden Supportive Living Champaign		Champaign, IL	
Eve Assisted Living		Hinsdale, IL	
Eden Supportive Living - South Shore		Chicago, 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).

Facility Name: Eden South Shore

Report Period Beginning:

11/6/17

Ending:

12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land 25,000 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	140			2017	\$ 6,661,158	\$ 30,308	28	\$ 30,308	\$	\$ 30,308	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)				\$ 6,661,158	\$ 30,308		\$ 30,308	\$	\$ 30,308	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	\$ 249,180	\$ 4,435	\$ 4,435	\$	7	\$ 4,435	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 249,180	\$ 4,435	\$ 4,435	\$		\$ 4,435	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 South Shore

Report Period Beginning: 11/6/17

Ending: 2/31/2017

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

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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1						/ /	\$	\$	/ /		\$	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$	\$			\$	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$	\$			\$	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 South Shore

Report Period Beginning: 11/6/17

Ending:

12/31/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,940,642	\$	1
2	Cash-Patient Deposits	14,800		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	143,055		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):	224,265		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,322,762	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	6,661,158		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	249,177		16
17	Accumulated Depreciation (book methods)	(34,743)		17
18	Deferred Charges	106,132		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,179)		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)	\$ 7,005,545	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,328,307	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 23,008	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,285		28
29	Short-Term Notes Payable	750,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	6,988		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)	\$ 793,281	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	2,103,055		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)	\$ 2,103,055	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,896,336	\$	45
46	TOTAL EQUITY	\$ 6,431,971	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,328,307	\$	47

*(See instructions.)

Facility Name: Eden South Shore

Report Period Beginning: 11/6/17

Ending:

12/31/2017

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	\$ 175,118	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 175,118	3
B. Other Operating Revenue			
4	Special Services	21,155	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)	\$ 21,155	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)	\$ 196,302	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	128,069	19
20	Health Care/ Personal Care	39,938	20
21	General Administration	261,334	21
B. Capital Expense			
22	Ownership	218,214	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)	\$ 647,555	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (451,253)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (451,253)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 29,358	32
33	Private Pay - Net Inpatient Revenue	145,760	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 175,118	37