

		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>1000102</u></p> <p>Facility Name: <u>Eden Supportive Lvg N Aurora</u></p> <hr/> <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>) Fax # ()</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>8/6/08</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>630</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>1/1/2017</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%;">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. 201 Houston Street, 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>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Paul H. Wieland President</u>			(Firm Name & Address) <u>Wieland & Company, Inc. 201 Houston Street, 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 Supportive Lvg N Aurora

Report Period Beginning: 1/1/2017 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	144	Single Unit Apartment	144	52,704	1
2	6	Double Unit Apartment	6	2,196	2
3		Other		2,196	3
4	150	TOTALS	150	57,096	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	52,049	182		52,231	5
6	Double Unit	3,547			3,547	6
7	Other					7
8	TOTALS	55,596	182		55,778	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.69%

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

280 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 20 (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 Supportive Lvg N Aurora

Report Period Beginning:

1/1/2017

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	320,408	316,106		636,514		636,514	1
2	Housekeeping, Laundry and Maintenance	274,030	81,759	109,844	465,633		465,633	2
3	Heat and Other Utilities			247,838	247,838		247,838	3
4	Other (specify):							4
5	TOTAL General Services	594,438	397,865	357,682	1,349,985		1,349,985	5
B. Health Care and Programs								
6	Health Care/ Personal Care	348,565	2,910		351,475		351,475	6
7	Activities and Social Services	56,762	9,448	27,688	93,898		93,898	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	405,327	12,358	27,688	445,373		445,373	9
C. General Administration								
10	Administrative and Clerical	396,945	31,100	37,720	465,765		465,765	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			209,496	209,496		209,496	12
13	Insurance-Property, Liability and Malpractice			165,653	165,653		165,653	13
14	Other (specify): Bad debt			615,000	615,000		615,000	14
15	TOTAL General Administration	396,945	31,100	1,027,869	1,455,914		1,455,914	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,396,710	441,323	1,413,239	3,251,272		3,251,272	16
Capital Expenses								
D. Ownership								
17	Depreciation			360,539	360,539		360,539	17
18	Interest			343,721	343,721		343,721	18
19	Real Estate Taxes			92,079	92,079		92,079	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			108,568	108,568		108,568	22
23	TOTAL Ownership			904,907	904,907		904,907	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,396,710	441,323	2,318,146	4,156,179		4,156,179	24

Facility Name: Eden Supportive Lvg N Aurora

Report Period Beginning: 1/1/2017

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	\$ 33.65	1
2	Licensed Practical Nurses	1	22.00	2
3	Certified Nurse Assistants	11	11.41	3
4	Activity Director & Assistants	2	14.22	4
5	Social Service Workers			5
6	Head Cook	4	13.81	6
7	Cook Helpers/Assistants	4	10.25	7
8	Dishwashers	2	9.44	8
9	Maintenance Workers	3	14.35	9
10	Housekeepers	5	10.51	10
11	Laundry	1	14.19	11
12	Managers	4	31.40	12
13	Other Administrative	2	13.29	13
14	Clerical			14
15	Marketing	1	28.76	15
16	Other			16
17	Total (lines 1 thru 16)	41	\$ 17.48	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	\$ 51,935	1
2					2
3					3
4					4
5					5
Total				\$ 51935	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 Supportive Living - Chicago		Chicago, 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: Eden Services, Inc. If yes, what is the value of those services? \$ 51,934

(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:

1/1/2017

Ending:

12/31/2017

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	\$	\$ 2,201,076	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Rehab & Construction		2006	2007-2008	2,052,059		5			2,052,059	6
7	Rehab & Construction		2006	2007-2008	411,673		7			411,673	7
8	Rehab & Construction		2006	2007-2008	900,585	60,069	15	60,069		570,610	8
9	Rehab & Construction		2009	2009	7,400	269	28	269		2,387	9
10	Rehab & Construction		2010	2010	49,616	1,804	28	1,804		14,357	10
11	Rehab & Construction		2011	2011	2,510	91	28	91		595	11
12	Rehab & Construction		2012	2012	13,609	495	28	495		2,949	12
13	Rehab & Construction		2014	2014	8,408	1,682	5	1,682		5,887	13
14	Rehab & Construction		2015	2015	50,190	1,825	28	1,825		3,878	14
15	Rehab & Construction		2015	2015	23,050	1,971	15	1,971		5,314	15
16	Rehab & Construction		2016	2016	197,191	9,369	28	9,369		17,521	16
	Rehab & Construction		2017	2017	372,290	15,471	28	15,471		15,471	
17	TOTAL (lines 1 thru 16)				\$ 10,545,628	\$ 327,824		\$ 327,824	\$	\$ 5,303,777	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	\$ 243,763	\$ 32,715	\$ 32,715	\$	5 to 7	\$ 176,180	18
19	Vehicles	19,172				5	19,172	19
20	TOTAL (lines 18 and 19)		\$ 262,935	\$ 32,715	\$ 32,715		\$ 195,352	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: 1/1/2017

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		Hsng & Healthcare Fin.		X	Acquisition/construction/rehab/refi	6/15/12	\$ 11,344,500	\$ 10,322,393	7/1/47	3.3000	\$ 343,721	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 11,344,500	\$ 10,322,393			\$ 343,721	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 11,344,500	\$ 10,322,393			\$ 343,721	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 Lvg N Aurora

Report Period Beginning: 1/1/2017

Ending:

12/31/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 830,052	\$	1
2	Cash-Patient Deposits	142,472		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 615,000)	2,448,282		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,092		6
7	Other Prepaid Expenses	26,311		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,514,209	\$	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	10,545,628		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	262,935		16
17	Accumulated Depreciation (book methods)	(5,499,129)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	267,399		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,007,604	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,521,813	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 82,913	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	138,913		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,605		30
31	Accrued Taxes Payable	98,000		31
32	Accrued Interest Payable	28,386		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Current portion of mortgage payable	209,480		35
36	Accounts payable, entity	(93,818)		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 506,479	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	9,976,328		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)	\$ 9,976,328	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,482,807	\$	45
46	TOTAL EQUITY	\$ (960,994)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,521,813	\$	47

*(See instructions.)

Facility Name: Eden Supportive Lvg N Aurora

Report Period Beginning: 1/1/2017

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	\$ 6,015,162	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 6,015,162	3
B. Other Operating Revenue			
4	Special Services		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)	\$	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	20,121	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 20,121	14
D. Other Revenue (specify):			
15	Commercial rents	13,200	15
16	Other revenues	11,385	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 24,585	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 6,059,868	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	1,349,985	19
20	Health Care/ Personal Care	445,373	20
21	General Administration	1,455,914	21
B. Capital Expense			
22	Ownership	904,907	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)	\$ 4,156,179	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 1,903,689	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 1,903,689	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 3,915,430	32
33	Private Pay - Net Inpatient Revenue	2,099,732	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 6,015,162	37

Eden Fox Valley
01/01/2017 to 12/31/2017

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

Mortgage insurance premium	\$ 51,990
Asset management fees	51,935
Entity expense - legal	-
Amortization expense	<u>4,643</u>
	<u><u>\$108,568</u></u>