

		FOR BHF USE			

LL2

Supportive Living Facility

2014

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2014)

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.

I. Facility ID Number: 1000146

Facility Name: Eden Supportve Lvg Champaign

Address: 222 N State Street Champaign 61820

Number City Zip Code

County: Champaign

Telephone Number: (217) 903-5900 Fax # (217) 378-6829

Federal Employer ID Number:

Date Current Owners were Certified: 10/31/2014

Type of Ownership:

<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 checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:

Name: Mitch Hamblet Telephone Number: (217) 903-5900

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2014 to 12/31/2014 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) (Date)

(Type or Print Name) Michael J. Hamblet, Jr.

(Title) Managing Member

Paid
Preparer

(Signed) (Date)

(Print Name and Title) Paul H. Wieland
President

(Firm Name & Address) Wieland & Company, Inc.
12 W. Wilson Street, Batavia, IL 60510

(Telephone) (630) 406-4490 Fax # (630) 406-4491

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

Facility Name **Eden Supportve Lvg Champaign**

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

Date of change in certified units

12/31 /14

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	149	Single Unit Apartment	54,385	54,385	1		
2	1	Double Unit Apartment	730	760	2		
3		Other			3		
4	150	TOTALS	55,145	55,145	4		

B. Census-For the entire report period.

	1 Type of Unit	2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	32,485	1,095		33,580	5
6	Double Unit	730			730	6
7	Other					7
8	TOTALS	33,215	1,095		34,310	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) **62.22%**

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

179 Also, indicate the number of unpaid bed-hold days the SLF
184 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

ACCUAL		MODIFIED	
CASH*	<input type="checkbox"/>	CASH*	<input type="checkbox"/>

I. Is your fiscal year identical to your tax year? ☒ YES ☐ NO

Tax Year: 12/31/2014 **Fiscal Year:** 12/31/2014

* 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.

STATE OF ILLINOIS

Page 3

Facility Name: Eden Supportve Lvg Champaign

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	165,541	201,763		367,304		367,304	1
2	Housekeeping, Laundry and Maintenance	81,983	54,790	82,283	219,056		219,056	2
3	Heat and Other Utilities			146,588	146,588		146,588	3
4	Other (specify):							4
5	TOTAL General Services	247,524	256,553	228,871	732,948		732,948	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	246,562	3,806		250,368		250,368	6
7	Activities and Social Services	25,000		12,799	37,799		37,799	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	271,562	3,806	12,799	288,167		288,167	9
	C. General Administration							
10	Administrative and Clerical	383,755	30,895	111,965	526,615		526,615	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			100,961	100,961		100,961	12
13	Insurance-Property, Liability and Malpractice			27,856	27,856		27,856	13
14	Other (specify):							14
15	TOTAL General Administration	383,755	30,895	240,782	655,432		655,432	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	902,841	291,254	482,452	1,676,547		1,676,547	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			783,974	783,974		783,974	17
18	Interest			611,085	611,085		611,085	18
19	Real Estate Taxes			41,734	41,734		41,734	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): See Statement 1			107,256	107,256		107,256	22
23	TOTAL Ownership			1,544,049	1,544,049		1,544,049	23
24	GRAND TOTAL (Sum of lines 16 and 23)	902,841	291,254	2,026,501	3,220,596		3,220,596	24

Facility Name: Eden Supportve Lvg Champaign

Report Period Beginning 01/01/2014 Ending: 12/31/2014

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 29.02	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	15	9.80	3
4	Activity Director & Assistants	2	12.00	4
5	Social Service Workers			5
6	Head Cook	3	10.09	6
7	Cook Helpers/Assistants	9	8.81	7
8	Dishwashers	1	8.50	8
9	Maintenance Workers	2	13.50	9
10	Housekeepers	2	9.00	10
11	Laundry			11
12	Managers	4	21.62	12
13	Other Administrative	7	10.00	13
14	Clerical			14
15	Marketing	1	23.08	15
16	Other			16
17	Total (lines 1 thru 16)	47	\$ 155.42	17

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	
Eve Assisted Living		Hinsdale, IL	
Eden Fox Valley		North Aurora, IL	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
				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).

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 2014			\$	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

Facility Name: Eden Supportve Lvg Champaign

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	\$ 20,682,671	\$ 647,682	40	\$ 647,682	\$	\$ 809,518	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)				\$ 20,682,671	\$ 647,682		\$ 647,682	\$	\$ 809,518	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	\$ 694,987	\$ 136,292	\$ 136,292	\$	5	\$ 168,896	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 694,987	\$ 136,292	\$ 136,292	\$		\$ 168,896	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 Supportve Lvg Champaign

Report Period Beginning: 01/01/2014 Ending: 2/31/2014

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: n/a

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 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	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	\$ 14,163,525	8/1/53	3.7600	\$ 521,085	1
2	2012B Bonds-surplus cash		x	Purchase money	6/1/12	1,000,000	1,000,000	4/1/29	9.0000	90,000	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 15,203,987	\$ 15,163,525			\$ 611,085	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 15,203,987	\$ 15,163,525			\$ 611,085	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.

STATE OF ILLINOIS

Page 7

Facility Name: Eden Supportive Lvg Champaign

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 162,517	\$	1
2	Cash-Patient Deposits	18,928		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>none</u>)	586,595		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	64,717		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 832,757	\$	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	20,682,671		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	694,987		16
17	Accumulated Depreciation (book methods)	(978,414)		17
18	Deferred Charges	445,488		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	146,858		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,331,590	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 22,164,347	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 70,607	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,077		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	47,000		31
32	Accrued Interest Payable	111,879		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Current portion of mortgage payable	165,699		35
36	Accrued wages payable	20,982		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 426,244	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	13,997,826		39
40	Bonds Payable	1,000,000		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)	\$ 17,247,826	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 17,674,070	\$	45
46	TOTAL EQUITY	\$ 4,490,277	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 22,164,347	\$	47

*(See instructions.)

Facility Name: Eden Supportve Lvg Champaign

Report Period Beginning: 01/01/2014

Ending:

12/31/2014

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

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,035,127	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,035,127	3
	B. Other Operating Revenue		
4	Special Services	624	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)	\$ 624	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	19	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 19	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)	\$ 2,035,770	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	732,948	19
20	Health Care/ Personal Care	288,167	20
21	General Administration	655,432	21
	B. Capital Expense		
22	Ownership	1,544,049	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)	\$ 3,220,596	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (1,184,826)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (1,184,826)	31

Eden Supportive Living of Champaign
01/01/2014 to 12/31/2013\4

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

Mortgage insurance premium	\$ 95,833
Amortization expense	<u>11,423</u>
	<u><u>\$107,256</u></u>

