

		FOR BHF USE			

LL2

Supportive Living Facility

2019

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2019)

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: 1000155

Facility Name: Eden South Shore

Address: 7156 S Dorchester Av Chicago 60619

County: Cook

Telephone Number: (773) 466-6868 Fax # (773) 466-6833

Federal Employer ID Number:

Date Current Owners were Certified: 11/06/17

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Mitch Hamblet Telephone Number: (630) 929-3333
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 to 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. 22 S. Batavia Ave., 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

Ending:

12/31/2019

Facility Name: Eden South Shore

Report Period Beginning:

Ending:

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	361,066	387,579		748,645		748,645	1
2	Housekeeping, Laundry and Maintenance	213,624	51,570	122,270	387,464		387,464	2
3	Heat and Other Utilities			194,548	194,548		194,548	3
4	Other (specify):							4
5	TOTAL General Services	574,690	439,149	316,818	1,330,657		1,330,657	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	442,677	1,579		444,256		444,256	6
7	Activities and Social Services			4,224	4,224		4,224	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	442,677	1,579	4,224	448,480		448,480	9
	C. General Administration							
10	Administrative and Clerical	424,023	39,496	32,456	495,975		495,975	10
11	Marketing Materials, Promotions and Advertising			14,729	14,729		14,729	11
12	Employee Benefits and Payroll Taxes			188,013	188,013		188,013	12
13	Insurance-Property, Liability and Malpractice			113,884	113,884		113,884	13
14	Other (specify): See Statement 1			94,297	94,297		94,297	14
15	TOTAL General Administration	424,023	39,496	443,379	906,898		906,898	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,441,390	480,224	764,421	2,686,035		2,686,035	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			861,790	861,790		861,790	17
18	Interest			653,245	653,245		653,245	18
19	Real Estate Taxes			41,816	41,816		41,816	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):See Statement 2			153,540	153,540		153,540	22
23	TOTAL Ownership			1,710,391	1,710,391		1,710,391	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,441,390	480,224	2,474,812	4,396,426		4,396,426	24

Facility Name: Eden South Shore

Report Period Beginning:

Ending:

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	30.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	16	13.15	3
4	Activity Director & Assistants	1	15.00	4
5	Social Service Workers			5
6	Head Cook	1	17.83	6
7	Cook Helpers/Assistants	9	13.70	7
8	Dishwashers	2	13.00	8
9	Maintenance Workers	2	14.73	9
10	Housekeepers	5	13.34	10
11	Laundry			11
12	Managers	3	32.35	12
13	Other Administrative	6	13.08	13
14	Clerical	1	22.00	14
15	Marketing	1	26.44	15
16	Other			16
17	Total (lines 1 thru 16)	48	\$ 15.47	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 Fox Valley	North Aurora, IL
Eden Supportive Living Champaign	Champaign, IL
Eve Assisted Living	Hinsdale, IL
Eden Supportive Living Chicago	Chicago, IL

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	Affiliate Asset Management Fees			\$ 145,396	1
2					2
3					3
4					4
5					5
Total				\$ 145396	6

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1		\$		1
2		\$		2
Total		\$		3

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5

Facility Name: Eden South Shore

Report Period Beginning:

Ending:

VIII. OWNERSHIP COSTS

A. Purchase price of land 247,600 Year land was acquired 2005

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	\$ 19,440,564	\$ 812,120	7 TO 40	\$ 812,120	\$	\$ 1,793,039	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Carpeting			2018	14,865	2,973		2,973		3,345	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)				\$ 19,455,429	\$ 815,093		\$ 815,093	\$	\$ 1,796,384	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	\$ 334,272	\$ 46,697	\$ 46,697	\$		\$ 105,068	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 334,272	\$ 46,697	\$ 46,697	\$		\$ 105,068	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:

Ending:

IX. RENTAL COSTS

A. Building and Fixed Equipment na

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 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*		8. Is movable equipment rental included in building rental? ☐ YES ☐ NO
3	Original Building			/ /	\$			3	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.
4	Additions			/ /				4	
5				/ /				5	
6				/ /				6	
7	TOTAL				\$			7	

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	Lakeside Bank		X	Acquisition/construction	10/14/15	\$ 15,760,000	\$ 14,953,837	10/28/22	4.2500	\$ 653,245	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 15,760,000	\$ 14,953,837			\$ 653,245	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 15,760,000	\$ 14,953,837			\$ 653,245	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:

Ending:

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of _____

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,474,468	\$	1
2	Cash-Patient Deposits	30,035		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,746,168		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,531		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,261,202	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	247,600		13
14	Buildings, at Historical Cost	19,455,429		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	334,272		16
17	Accumulated Depreciation (book methods)	(1,901,452)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			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)	\$ 18,135,849	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 21,397,051	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 98,911	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,114		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	16,926		30
31	Accrued Taxes Payable	41,200		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Current portion on mortgage note	402,000		35
36	Due to affiliates	729,817		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,318,968	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	14,551,837		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Unamortized finance costs	(288,031)		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 14,263,806	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 15,582,774	\$	45
46	TOTAL EQUITY	\$ 5,814,277	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 21,397,051	\$	47

*(See instructions.)

Facility Name: Eden South Shore

Report Period Beginning:

Ending:

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	\$ 6,402,809	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 6,402,809	3
	B. Other Operating Revenue		
4	Special Services	10,972	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)	\$ 10,972	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	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)	\$ 6,413,781	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,330,657	19
20	Health Care/ Personal Care	448,480	20
21	General Administration	906,898	21
	B. Capital Expense		
22	Ownership	1,710,391	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)	\$ 4,396,426	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 2,017,355	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 2,017,355	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 4,597,539	32
33	Private Pay - Net Inpatient Revenue	1,805,270	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 6,402,809	37

ENT 1 PART IV, LINE 14, COLUMN 3 - OTHER GENERAL ADMINISTRATION

accounting fees	\$ 2,500
	\$ 78,017
eous taxes and licenses	<u> 13,780</u>
	<u><u> \$ 94,297</u></u>

ENT 2 PART IV, LINE 22, COLUMN 3 - OTHER OWNERSHIP

agement fees	\$ 145,396
tion expense	<u> 8,144</u>
	<u><u> \$ 153,540</u></u>