

		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: 1000146

Facility Name: Eden Supportive Lvg Chmpaign

Address: 222 North State St 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: 10/31/14

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust

IRS Exemption Code _____

☒ PROPRIETARY ☐ GOVERNMENTAL

☐ Individual ☐ State
☐ Partnership ☐ County
☐ Corporation ☐ Other _____
☐ "Sub-S" Corp. _____
☒ Limited Liability Co. _____
☐ Trust
☐ Other _____

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

Name: Mitch Hamblet Telephone Number: (312) 263-7347
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 1/1/19 to 12/31/19 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.
232 S. Batavia Avenue, 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 Supportive Lvg Chmpaign Report Period Beginning: 1/1/19 Ending: 12/31/19

III. STATISTICAL DATA

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

Date of change in certified units 12/31/2019

	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	150	Single Unit Apartment	150	54,750	1
2		Double Unit Apartment			2
3		Other			3
4	150	TOTALS	150	54,750	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	44,111	1,590		45,701	5
6	Double Unit					6
7	Other					7
8	TOTALS	44,111	1,590		45,701	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 83.47%

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

389 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. 8660 (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: 12/31/19 Fiscal Year: 12/31/19

* 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 principal? _____
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 principal? _____
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 principal? _____
If no, explain. _____

STATE OF ILLINOIS

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Facility Name: Eden Supportive Lvg Chmpaign

Report Period Beginning:

1/1/19

Ending:

12/31/19

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	335,586	312,034		647,620		647,620	1
2	Housekeeping, Laundry and Maintenance	229,681	32,294	83,161	345,136		345,136	2
3	Heat and Other Utilities			163,488	163,488		163,488	3
4	Other (specify):							4
5	TOTAL General Services	565,267	344,328	246,649	1,156,244		1,156,244	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	387,614	2,493		390,107		390,107	6
7	Activities and Social Services	52,857		14,105	66,962		66,962	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	440,471	2,493	14,105	457,069		457,069	9
	C. General Administration							
10	Administrative and Clerical	349,627	52,058	77,906	479,591		479,591	10
11	Marketing Materials, Promotions and Advertising			7,461	7,461		7,461	11
12	Employee Benefits and Payroll Taxes			206,878	206,878		206,878	12
13	Insurance-Property, Liability and Malpractice			118,531	118,531		118,531	13
14	Other (specify):			800,000	800,000		800,000	14
15	TOTAL General Administration	349,627	52,058	1,210,776	1,612,461		1,612,461	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,355,365	398,879	1,471,530	3,225,774		3,225,774	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			543,566	543,566		543,566	17
18	Interest			502,261	502,261		502,261	18
19	Real Estate Taxes			87,934	87,934		87,934	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			198,794	198,794		198,794	22
23	TOTAL Ownership			1,332,555	1,332,555		1,332,555	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,355,365	398,879	2,804,085	4,558,329		4,558,329	24

Facility Name: Eden Supportive Lvg Chmpaign

Report Period Beginning 1/1/19 Ending: 12/31/19

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	32.69	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	14	13.43	3
4	Activity Director & Assistants	2	15.09	4
5	Social Service Workers			5
6	Head Cook	1	20.67	6
7	Cook Helpers/Assistants	11	11.90	7
8	Dishwashers	2	9.75	8
9	Maintenance Workers	3	15.44	9
10	Housekeepers	6	10.42	10
11	Laundry			11
12	Managers	4	29.34	12
13	Other Administrative	6	11.07	13
14	Clerical	1	18.26	14
15	Marketing	1	15.87	15
16	Other			16
17	Total (lines 1 thru 16)	52	\$ 204	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
Eden Supportive Living - South Shore	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: Eden Services, Inc. If yes, what is the value of those services? \$ 145,456

(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		40	\$ 145,456	1
2					2
3					3
4					4
5					5
Total				\$ 145456	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

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	\$ 20,682,670	\$ 524,112	15-40	\$ 524,112	\$	\$ 3,894,687	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Flooring			2016	10,223	1,460	7	1,460		5,112	6
7	Waterfall			2016	4,112	587	7	587		2,057	7
8	Flooring			2017	3,021	431	7	431		917	8
9	Flooring			2018	4,022	575	7	575		862	9
10	Flooring			2018	3,456	494	7	494		741	10
11	Windows			2019	40,736	679	40	679		679	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 20,748,240	\$ 528,338		\$ 528,338	\$	\$ 3,905,055	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	\$ 770,993	\$ 15,228	\$ 15,228	\$	5	\$ 724,549	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)		\$ 770,993	\$ 15,228	\$ 15,228		\$ 724,549	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 Chmpaign Report Period Beginning: 1/1/19 Ending: 12/31/19

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 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	\$ 13,269,168	8 / 1 / 53	3.7600	\$ 502,261	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 14,203,987	\$ 13,269,168			\$ 502,261	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 14,203,987	\$ 13,269,168			\$ 502,261	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.

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Facility Name: Eden Supportive Lvg Chmpaign

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12/31/19

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/19

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,622,370	\$	1
2	Cash-Patient Deposits	23,958		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 800,000)	2,993,944		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,660		6
7	Other Prepaid Expenses	11,964		7
8	Accounts Receivable (owners or related parties)	3,342		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,701,238	\$	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	20,748,240		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	770,993		16
17	Accumulated Depreciation (book methods)	(4,629,604)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	669,076		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,898,705	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 23,599,943	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 109,796	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,210		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	21,092		30
31	Accrued Taxes Payable	92,400		31
32	Accrued Interest Payable	41,577		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Current portion of mortgage payable	199,913		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 484,988	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	12,680,882		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Deferred development fee	2,250,000		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 14,930,882	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 15,415,870	\$	45
46	TOTAL EQUITY	\$ 8,184,073	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 23,599,943	\$	47

*(See instructions.)

Facility Name: Eden Supportive Lvg Chmpaign

Report Period Beginning: 1/1/19

Ending:

12/31/19

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	\$ 4,977,200	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,977,200	3
	B. Other Operating Revenue		
4	Special Services	11,747	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)	\$ 11,747	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	731	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 731	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)	\$ 4,989,678	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,156,244	19
20	Health Care/ Personal Care	457,069	20
21	General Administration	1,612,461	21
	B. Capital Expense		
22	Ownership	1,332,555	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)	\$ 4,558,329	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 431,349	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 431,349	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,270,875	32
33	Private Pay - Net Inpatient Revenue	3,706,325	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 4,977,200	37

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

\$ 800,000

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

insurance premium	\$ 41,915
management fees	145,456
union expense	<u>11,423</u>
	<u><u>\$ 198,794</u></u>