

		FOR BHF USE			

LL2

Supportive Living Facility

**2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)**

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: 1000025</p> <p>Facility Name: <u>Asbury Gardens</u></p> <hr/> <p>Address: <u>210 Airport Rd</u> <u>North Aurora</u> <u>60542</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Kane</u></p> <p>Telephone Number: (<u>630</u>) <u>896-7778</u> Fax # (<u>630</u>) <u>896-6759</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>5/5/03</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input 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 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>Michael Zahtz</u> Telephone Number: (<u>847</u>) <u>676-1700</u></p> <p>Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 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>1/1/18</u> to <u>12/31/18</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 Zahtz</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO</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) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) (<u> </u>) _____</td> <td>Fax # (<u> </u>) _____</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 Zahtz</u>			(Title) <u>CFO</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) (<u> </u>) _____	Fax # (<u> </u>) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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	(Telephone) (<u> </u>) _____	Fax # (<u> </u>) _____																																												

Facility Name Asbury Gardens

Report Period Beginning: 1/1/18 Ending: 12/31/18

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	117	Single Unit Apartment	117	42,705	1
2	53	Double Unit Apartment	53	19,345	2
3		Other		19,273	3
4	170	TOTALS	170	81,323	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	29,280	11,906		41,186	5
6	Double Unit	30,919	7,628		38,547	6
7	Other					7
8	TOTALS	60,199	19,534		79,733	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.04%

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

1,419 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: 12/31/18 Fiscal Year:

* 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.

Facility Name: Asbury Gardens

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	278,220	485,350	4,294	767,864		767,864	1
2	Housekeeping, Laundry and Maintenance	251,185	78,002	142,005	471,192		471,192	2
3	Heat and Other Utilities			212,927	212,927		212,927	3
4	Other (specify): Scavenger			20,395	20,395		20,395	4
5	TOTAL General Services	529,405	563,352	379,621	1,472,378		1,472,378	5
B. Health Care and Programs								
6	Health Care/ Personal Care	1,733,973	20,332	105,874	1,860,179		1,860,179	6
7	Activities and Social Services	83,750	29,148	17,697	130,595		130,595	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	1,817,723	49,480	123,571	1,990,774		1,990,774	9
C. General Administration								
10	Administrative and Clerical	272,159	80,745	736,039	1,088,943	7,572	1,096,515	10
11	Marketing Materials, Promotions and Advertising	98,122	34,914	77,653	210,689		210,689	11
12	Employee Benefits and Payroll Taxes	345,375			345,375		345,375	12
13	Insurance-Property, Liability and Malpractice	137,905			137,905	133,516	271,421	13
14	Other (specify):							14
15	TOTAL General Administration	853,561	115,659	813,692	1,782,912	141,088	1,924,000	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	3,200,689	728,491	1,316,884	5,246,064	141,088	5,387,152	16
Capital Expenses								
D. Ownership								
17	Depreciation					682,801	682,801	17
18	Interest					646,131	646,131	18
19	Real Estate Taxes					159,670	159,670	19
20	Rent -- Facility and Grounds			1,663,278	1,663,278	(1,663,278)		20
21	Rent -- Equipment			9,702	9,702		9,702	21
22	Other (specify):							22
23	TOTAL Ownership			1,672,980	1,672,980	(174,676)	1,498,304	23
24	GRAND TOTAL (Sum of lines 16 and 23)	3,200,689	728,491	2,989,864	6,919,044	(33,588)	6,885,456	24

Facility Name: Asbury Gardens

Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	4	\$ 30.98	1
2	Licensed Practical Nurses	8	28.73	2
3	Certified Nurse Assistants	32	14.86	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	13.68	6
7	Cook Helpers/Assistants	6	15.66	7
8	Dishwashers	8	11.60	8
9	Maintenance Workers	3	24.77	9
10	Housekeepers	6	10.29	10
11	Laundry			11
12	Managers	1	55.00	12
13	Other Administrative	2	17.92	13
14	Clerical	2	29.48	14
15	Marketing	1	34.46	15
16	Other			16
17	Total (lines 1 thru 16)	74	\$	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				\$	1
2					2
3					3
4					4
5					5
Total				\$	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
Asbury Court		Des Plaines	
Asbury of Kankakee		Kankakee	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Asbury Healthcare		Skokie		Management	
EJR Enterprises		North Aurora		Property	

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: Asbury Gardens

Report Period Beginning:

1/1/18

Ending:

12/31/18

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

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					\$	\$		\$	\$	\$	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)				\$	\$		\$	\$	\$	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	\$	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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: Asbury Gardens

Report Period Beginning: 1/1/18

Ending: 12/31/18

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					Amount 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: Asbury Gardens

Report Period Beginning: 1/1/18

Ending:

12/31/18

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 520,603	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>41,500</u>)	1,488,918		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	99,443		6
7	Other Prepaid Expenses	18,657		7
8	Accounts Receivable (owners or related parties)	1,562,150		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,689,771	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,689,771	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 211,141	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	92,928		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	133,129		30
31	Accrued Taxes Payable	753		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Due to Affiliates	271,984		35
36	See Attachment1	16,107		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 726,042	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			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)	\$	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 726,042	\$	45
46	TOTAL EQUITY	\$ 2,963,729	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 3,689,771	\$	47

*(See instructions.)

Facility Name: Asbury Gardens

Report Period Beginning: 1/1/18

Ending:

12/31/18

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	\$ 9,276,409	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 9,276,409	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services	2,237	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	1,200	8
9	Non-Resident Meals	4,428	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 7,865	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	19,246	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 19,246	14
D. Other Revenue (specify):			
15	Room Rental	300	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 300	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 9,303,820	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	1,472,378	19
20	Health Care/ Personal Care	1,990,774	20
21	General Administration	1,782,912	21
B. Capital Expense			
22	Ownership	1,672,980	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)	\$ 6,919,044	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 2,384,776	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 2,384,776	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 4,254,017	32
33	Private Pay - Net Inpatient Revenue	5,022,392	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 9,276,409	37

Pg7 Other Current Liabilities:

Management Fee Payable	39,999.00
Clearing Acct	(30,096.00)
Prepaid Rent	5,487.00
Due to Employees	61.00
Due to programs	656.00
	<u>16,107.00</u>

Pg3 C. Related Party Expenses:

Accounting, Billing, Payroll Services, and Consulting	158,128.00
Dues	372.00
Amortization	77,393.00
Professional Fees	7,200.00
Interest	646,131.00
Depreciation	605,408.00
Real Estate Taxes	159,670.00
Insurance	133,516.00
Total Related Party Expenses	<u>1,787,818</u>

Expense Adjustments:

Interest	646,131	pg. 3 IV. 18
Dues	372	pg. 3 IV. 10
Depreciation	682,801	pg. 3 IV. 17
Real Estate Taxes	159,670	pg. 3 IV. 19
Insurance	133,516	pg. 3 IV. 13
Rent	(1,663,278)	pg. 3 IV. 20
Professional Fees	7,200	pg. 3 IV. 10
Total Expense Adj.	<u>(33,588)</u>	