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.

I. Facility ID Number: 100X025

Facility Name: Asbury Gardens Memory Care

Address: 210 Airport Rd (Number) North Aurora (City) 60542 (Zip Code)

County: Kane

Telephone Number: (630) 896-7778 **Fax #** (630) 896-6759

Federal Employer ID Number:

Date Current Owners were Certified: 5/5/03

Type of Ownership:

- ☐ VOLUNTARY, NON-PROFIT
  - ☐ Charitable Corp.
  - ☐ Trust
  - IRS Exemption Code
- ☐ PROPRIETARY
  - ☐ Individual
  - ☐ Partnership
  - ☐ Corporation
  - ☐ "Sub-S" Corp.
  - ☐ Limited Liability Co.
  - ☐ Trust
  - ☐ Other
- ☐ GOVERNMENTAL
  - ☐ State
  - ☐ County
  - ☐ Other

In the event there are further questions about this report, please contact:
Name: Michael Zahtz **Telephone Number:** (847) 676-1700
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 1/1/18 to 12/31/18 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 Zahtz
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 Asbury Gardens Memory Care 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 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	10	Single Unit Apartment	10		1
2	10	Double Unit Apartment	10		2
3		Other			3
4	20	TOTALS	20		4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit					5
6	Double Unit					6
7	Other					7
8	TOTALS					8

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

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

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

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*
[X]	[ ]	[ ]

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 Memory Care **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	5	6	
	A. General Services							
1	Dietary and Food Purchase	41,448	64,934	720	107,102		107,102	1
2	Housekeeping, Laundry and Maintenance	55,830	11,245	20,755	87,830		87,830	2
3	Heat and Other Utilities			31,721	31,721		31,721	3
4	Other (specify): Scavenger			3,038	3,038		3,038	4
5	**TOTAL General Services**	97,278	76,179	56,234	229,691		229,691	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	1,207,705	623	67,251	1,275,579		1,275,579	6
7	Activities and Social Services	12,842	5,126	2,636	20,604		20,604	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	1,220,547	5,749	69,887	1,296,183		1,296,183	9
	C. General Administration							
10	Administrative and Clerical	58,737	7,164	102,604	168,505	1,128	169,633	10
11	Marketing Materials, Promotions and Advertising	14,618	5,932	14,656	35,206		35,206	11
12	Employee Benefits and Payroll Taxes	124,307			124,307		124,307	12
13	Insurance-Property, Liability and Malpractice	20,545			20,545	19,891	40,436	13
14	Other (specify):							14
15	**TOTAL General Administration**	218,207	13,096	117,260	348,563	21,019	369,582	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,536,032	95,024	243,381	1,874,437	21,019	1,895,456	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					101,722	101,722	17
18	Interest					96,259	96,259	18
19	Real Estate Taxes					23,787	23,787	19
20	Rent -- Facility and Grounds			247,790	247,790	(247,790)		20
21	Rent -- Equipment			1,445	1,445		1,445	21
22	Other (specify):							22
23	**TOTAL Ownership**			249,235	249,235	(26,022)	223,213	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,536,032	95,024	492,616	2,123,672	(5,003)	2,118,669	24

Facility Name: Asbury Gardens Memory Care 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		$	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)		$	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				OTHER RELATED BUSINESS ENTITIES				
Name	1	City	2	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: _____ 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 Memory Care 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 Memory Care 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 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 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	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 Memory Care **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 Operating	2 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 41,500)	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 Operating	2 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 Memory Care **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.)

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,386,056	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,386,056	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		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)**	$ 1,386,056	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	229,691	19
20	Health Care/ Personal Care	1,296,183	20
21	General Administration	348,563	21
	B. Capital Expense		
22	Ownership	249,235	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)**	$ 2,123,672	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (737,616)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (737,616)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 834,361	32
33	Private Pay - Net Inpatient Revenue	551,695	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,386,056	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
	16,107.00

Pg3 C. Related Party Expenses:

Accounting, Billing, Payroll Services, and Consultin	23,558.00
Dues	55.00
Amortization	11,530.00
Professional Fees	7,200.00
Interest	96,259.00
Depreciation	90,192.00
Real Estate Taxes	23,787.00
Insurance	19,891.00
Total Related Party Expenses	**272,472**

Expense Adjustments:

Interest	96,259	pg. 3 IV. 18
Dues	55	pg. 3 IV. 10
Depreciation	101,722	pg. 3 IV. 17
Real Estate Taxes	23,787	pg. 3 IV. 19
Insurance	19,891	pg. 3 IV. 13
Rent	(247,790)	pg. 3 IV. 20
Professional Fees	7,200	pg. 3 IV. 10
Total Expense Adj.	**1,124**	