

		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:** 100030

**Facility Name:** Asbury of Kankakee Supportive Living LLC

**Address:** 1975 E Court St Kankakee 6901  
Number City Zip Code

**County:** Kankakee

**Telephone Number:** (847 ) 936-1000 **Fax #** ( )

**Federal Employer ID Number:** \_\_\_\_\_

**Date Current Owners were Certified:** 10/1/16

**Type of Ownership:**

<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
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" 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:** 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Michael Zahtz</u>	
	(Title) <u>Manager</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>( )</u> _____	<b>Fax #</b> <u>( )</u> _____

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 of Kankakee Supportive Living LLC

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	62	Single Unit Apartment	62	22,630	1
2	18	Double Unit Apartment	18	6,570	2
3		Other		1,420	3
4	80	TOTALS	80	30,620	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	17,482	1,675		19,157	5
6	Double Unit	2,308	533		2,841	6
7	Other					7
8	TOTALS	19,790	2,208		21,998	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 71.84%

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

653 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)

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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 of Kankakee Supportive Living LLC

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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	132,562	10,399	108,779	251,740		251,740	1
2	Housekeeping, Laundry and Maintenance	105,135	51,832	103,899	260,866		260,866	2
3	Heat and Other Utilities			120,344	120,344		120,344	3
4	Other (specify): Scavenger			17,968	17,968		17,968	4
5	<b>TOTAL General Services</b>	237,697	62,231	350,990	650,918		650,918	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	282,410	4,999	22,075	309,484		309,484	6
7	Activities and Social Services	3,924	8,113	130	12,167		12,167	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	286,334	13,112	22,205	321,651		321,651	9
<b>C. General Administration</b>								
10	Administrative and Clerical	118,880	14,063	263,424	396,367	10,404	406,771	10
11	Marketing Materials, Promotions and Advertising	22,154	21,319	56,692	100,165		100,165	11
12	Employee Benefits and Payroll Taxes	86,474			86,474		86,474	12
13	Insurance-Property, Liability and Malpractice	64,863			64,863	4,807	69,670	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	292,371	35,382	320,116	647,869	15,211	663,080	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	816,402	110,725	693,311	1,620,438	15,211	1,635,649	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			1,095	1,095	56,751	57,846	17
18	Interest					237,523	237,523	18
19	Real Estate Taxes					92,073	92,073	19
20	Rent -- Facility and Grounds			402,000	402,000	(402,000)		20
21	Rent -- Equipment			5,194	5,194		5,194	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			408,289	408,289	(15,653)	392,636	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	816,402	110,725	1,101,600	2,028,727	(442)	2,028,285	24

Facility Name: Asbury of Kankakee Supportive Living LLC

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	0	\$ 27.58	1
2	Licensed Practical Nurses	1	22.61	2
3	Certified Nurse Assistants	7	10.99	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	2	13.56	6
7	Cook Helpers/Assistants	2	10.87	7
8	Dishwashers	4	9.70	8
9	Maintenance Workers	2	21.00	9
10	Housekeepers	2	9.50	10
11	Laundry			11
12	Managers	1	45.91	12
13	Other Administrative	0	9.00	13
14	Clerical	1	28.25	14
15	Marketing	0	30.77	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>22</b>	<b>\$</b>	<b>17</b>

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
				<b>Total</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>3</b>

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
See attachment1			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Asbury Healthcare		Lincolnwood		Management	

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 of Kankakee Supportive Living LLC

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
	<b>Improvement Type</b>										
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	<b>TOTAL (lines 1 thru 16)</b>				\$	\$		\$	\$	\$	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	<b>TOTAL (lines 18 and 19)</b>	\$	\$	\$	\$		\$	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	Floor Scrubber 2018	\$ 2,860	\$ 572	\$ 572	21
22	Ice Machine 2018	2,614	523	523	22
23					23
24	<b>TOTALS (lines 21, 22 and 23)</b>	\$ 5,474	\$ 1,095	\$ 1,095	24

Facility Name: Asbury of Kankakee Supportive Living LLC

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	<b>TOTAL</b>				\$			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					
		<b>A. Directly Facility Related</b>											
		<b>Long-Term</b>											
1						/ /	\$	\$	/ /		\$	1	
2						/ /			/ /			2	
3						/ /			/ /			3	
		<b>Working Capital</b>											
4						/ /			/ /			4	
5						/ /			/ /			5	
6						/ /			/ /			6	
7		<b>TOTAL Facility Related</b>						\$	\$			\$	7
		<b>B. Non-Facility Related</b>											
8						/ /			/ /			8	
9						/ /			/ /			9	
10		<b>TOTALS (lines 7, 8 and 9)</b>						\$	\$			\$	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 of Kankakee Supportive Living LLC**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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 105,034	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	560,608		3
	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	40,596		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	3,823		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 710,061	\$	10
	<b>B. Long-Term Assets</b>			
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	5,474		16
17	Accumulated Depreciation (book methods)	(1,095)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,379	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 714,440	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 81,195	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,883		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	Management Fee Payable	9,979		35
36	See attachment2	209,842		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 328,899	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42	Due to Asbury of Kankakee Realty	163,454		42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 163,454	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 492,353	\$	45
46	<b>TOTAL EQUITY</b>	\$ 222,087	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 714,440	\$	47

\*(See instructions.)

Facility Name: Asbury of Kankakee Supportive Living LLC

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	
<b>A. SLF Resident Care</b>			
	Gross SLF Resident Revenue	\$ 2,188,875	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 2,188,875</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services	967	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	203	8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 1,170</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	2,956	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 2,956</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 2,193,001</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	650,918	19
20	Health Care/ Personal Care	321,651	20
21	General Administration	663,080	21
<b>B. Capital Expense</b>			
22	Ownership	392,636	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 2,028,285</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 164,716</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$ 1,216</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 163,500</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 1,341,810	32
33	Private Pay - Net Inpatient Revenue	847,065	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 2,188,875</b>	<b>37</b>

**VII. RELATED ORGANIZATIONS**

**A. RELATED SLF's & HEALTH CARE BUSINESSES**

<u>Name</u>	<u>City</u>
<b>Asbury Gardens SLF</b>	<b>Aurora</b>
<b>Asbury Gardens SNF</b>	<b>Aurora</b>
<b>Asbury Court SLF</b>	<b>Des Plaines</b>
<b>Asbury Court SNF</b>	<b>Des Plaines</b>
<b>Moraine Court</b>	<b>Bridgeview</b>

**Pg7 Line 36 Other:**

Rent Payable	172,000.00
Due to Affiliates	20,389.00
Due to Residents	3,671.00
Other Current Liabilities	797.00
Due to HFS/Platinum	12,985.00
Total	<u>209,842.00</u>

**Pg4 Related Party Expenses**

VII. C.

<u>Description</u>	<u>Amount</u>
Accounting, Billing, Payroll Service	96,825.93
Property Taxes	92,072.64
Insurance	4,806.65
Depreciation	56,751.00
Interest	237,523.21
Bank Fees	4,709.92
Professional Fees	5,694.50
<b>Total Related Party Expenses</b>	<b><u>498,384</u></b>

**Pg3 Expense Adjustments:**

Other Fees	10,404.42	pg. 3 IV. 10
Property taxes	92,072.64	pg. 3 IV. 19
Insurance	4,806.65	pg. 3 IV. 13
Interest	237,523.21	pg. 3 IV. 18
Depreciation	56,751.00	pg. 3 IV. 17
Rent	(402,000.00)	pg. 3 IV. 20
<b>Total Adjustments</b>	<b><u>(442)</u></b>	