

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2017  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2017)**

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><b>I. Facility ID Number:</b> <u>100X025</u></p> <p><b>Facility Name:</b> <u>Asbury Gardens Memory Care</u></p> <hr/> <p><b>Address:</b> <u>210 Airport Rd</u> <u>North Aurora</u> <u>60542</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>Kane</u></p> <p><b>Telephone Number:</b> ( <u>630</u> ) <u>896-7778</u> Fax # ( <u>630</u> ) <u>896-6759</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>5/5/03</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>Michael Zahtz</u> <b>Telephone Number:</b> ( <u>847</u> ) <u>6776-1700</u></p> <p><b>Email Address:</b> _____</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	<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 _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/17</u> to <u>12/31/17</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 align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;"><b>Officer or Administrator of Provider</b></td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Michael Zahtz</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>CFO</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"><b>Paid Preparer</b></td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name &amp; Address) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) ( <u>    </u> ) _____</td> <td style="border: none;">Fax # ( <u>    </u> ) _____</td> </tr> </table> <p align="right"><b>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</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>Michael Zahtz</u>			(Title) <u>CFO</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) ( <u>    </u> ) _____	Fax # ( <u>    </u> ) _____
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Facility Name Asbury Gardens Memory Care

Report Period Beginning: 1/1/17 Ending: 12/31/17

**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	10	Single Unit Apartment	10	3,650	1
2	10	Double Unit Apartment	10	3,650	2
3		Other		3,305	3
4	20	TOTALS	20	10,605	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	2,909	564		3,473	5
6	Double Unit	5,702	814		6,516	6
7	Other					7
8	TOTALS	8,611	1,378		9,989	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 94.19%

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

145 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: 12/31/17 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 principle?             
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 principle?             
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 principle?             
If no, explain.

Facility Name: Asbury Gardens Memory Care

Report Period Beginning:

1/1/17

Ending:

12/31/17

## 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	37,785	65,425	465	103,675		103,675	1
2	Housekeeping, Laundry and Maintenance	54,060	10,792	43,749	108,601		108,601	2
3	Heat and Other Utilities			31,058	31,058		31,058	3
4	Other (specify): Scavenger			3,730	3,730		3,730	4
5	<b>TOTAL General Services</b>	<b>91,845</b>	<b>76,217</b>	<b>79,002</b>	<b>247,064</b>		<b>247,064</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	960,786	1,810	110,216	1,072,812		1,072,812	6
7	Activities and Social Services	66,201	5,720	4,153	76,074		76,074	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>1,026,987</b>	<b>7,530</b>	<b>114,369</b>	<b>1,148,886</b>		<b>1,148,886</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	17,747	6,497	139,562	163,806	976	164,782	10
11	Marketing Materials, Promotions and Advertising	20,101	3,350	16,353	39,804		39,804	11
12	Employee Benefits and Payroll Taxes	129,606			129,606		129,606	12
13	Insurance-Property, Liability and Malpractice	9,574			9,574	21,774	31,348	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>177,028</b>	<b>9,847</b>	<b>155,915</b>	<b>342,790</b>	<b>22,750</b>	<b>365,540</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,295,860</b>	<b>93,594</b>	<b>349,286</b>	<b>1,738,740</b>	<b>22,750</b>	<b>1,761,490</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation					105,068	105,068	17
18	Interest					101,444	101,444	18
19	Real Estate Taxes					16,158	16,158	19
20	Rent -- Facility and Grounds			272,096	272,096	(272,096)		20
21	Rent -- Equipment			43	43		43	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>272,139</b>	<b>272,139</b>	<b>(49,426)</b>	<b>222,713</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,295,860</b>	<b>93,594</b>	<b>621,425</b>	<b>2,010,879</b>	<b>(26,676)</b>	<b>1,984,203</b>	<b>24</b>

Facility Name: Asbury Gardens Memory Care

Report Period Beginning: 1/1/17

Ending: 12/31/17

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0	\$ 51.38	1
2	Licensed Practical Nurses	3	29.46	2
3	Certified Nurse Assistants	7	13.21	3
4	Activity Director & Assistants	3	17.43	4
5	Social Service Workers			5
6	Head Cook	0	37.70	6
7	Cook Helpers/Assistants	2	12.17	7
8	Dishwashers	0	11.14	8
9	Maintenance Workers	1	24.37	9
10	Housekeepers	2	13.17	10
11	Laundry			11
12	Managers	1	40.68	12
13	Other Administrative	0	17.51	13
14	Clerical	0	29.65	14
15	Marketing	0	36.53	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>18</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
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 Memory Care

Report Period Beginning:

1/1/17

Ending:

12/31/17

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		\$	\$	\$	21
22					22
23					23
24	<b>TOTALS (lines 21, 22 and 23)</b>	\$	\$	\$	24

Facility Name: Asbury Gardens Memory Care

Report Period Beginning: 1/1/17

Ending: 12/31/17

**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				
			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 Gardens Memory Care

Report Period Beginning: 1/1/17

Ending:

12/31/17

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,288,391	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>41,500</u> )	1,100,241		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,911		6
7	Other Prepaid Expenses	8,670		7
8	Accounts Receivable (owners or related parties)	2,338,806		8
9	Other(specify):	(32,213)		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,744,806	\$	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			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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,744,806	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 245,963	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	92,678		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,832		30
31	Accrued Taxes Payable	1,173		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes	(13,167)		34
	<b>Other Current Liabilities(specify):</b>			
35	Due to Affiliates	131,656		35
36	Other	90,667		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 644,802	\$	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				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 644,802	\$	45
46	<b>TOTAL EQUITY</b>	\$ 4,100,004	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 4,744,806	\$	47

\*(See instructions.)

Facility Name: Asbury Gardens Memory Care

Report Period Beginning: 1/1/17

Ending:

12/31/17

**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>			
1	Gross SLF Resident Revenue	\$ 1,406,491	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 1,406,491</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
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	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$</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>\$ 1,406,491</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	247,064	19
20	Health Care/ Personal Care	1,148,886	20
21	General Administration	342,790	21
<b>B. Capital Expense</b>			
22	Ownership	272,139	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>\$ 2,010,879</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (604,388)</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ (604,388)</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	745,525	32
33	Private Pay - Net Inpatient Revenue	660,966	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>\$ 1,406,491</b>	<b>37</b>



**Pg7**

**Other Current Liabilities:**

Management Fee Payable	105,457.00
Clearing Acct	(20,933.00)
Prepaid Rent	5,487.00
Due to programs	656.00
	<u>90,667.00</u>

**C. Related Party Expenses:**

Accounting, Billing, Payroll Services, and Consulting	27,546.00
Amortization	11,879.90
Professional Fees	976.00
Interest	101,444.00
Depreciation	93,188.00
Real Estate Taxes	16,158.00
Insurance	21,774.00
<b>Total Related Party Expenses</b>	<u><b>272,966</b></u>

**Expense Adjustments:**

Interest	101,444	pg. 3 IV. 18
Depreciation	105,068	pg. 3 IV. 17
Real Estate Taxes	16,158	pg. 3 IV. 19
Insurance	21,774	pg. 3 IV. 13
Rent	(272,096)	pg. 3 IV. 20
Professional Fees	976	pg. 3 IV. 10
<b>Total Expense Adj.</b>	<u><b>(26,676)</b></u>	