FOR BHF USE

LL2

Supportive Living Facility

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2020)

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 #** ( )

Federal Employer ID Number:

Date Current Owners were Certified: 5/5/2003

Type of Ownership:

[ ] VOLUNTARY, NON-PROFIT	[ ] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code	[ ] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[X] Limited Liability Co.	
	[ ] Trust	
	[ ] 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 1/1/2020 to 12/31/2020 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: 1/1/2020 Ending: 12/31/2020

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	37	Single Unit Apartment	37	13,542	1
2	21	Double Unit Apartment	21	7,686	2
3		Other		7,313	3
4	58	TOTALS	58	28,541	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	10,253	1,880		12,133	5
6	Double Unit	13,237	2,105		15,342	6
7	Other					7
8	TOTALS	23,490	3,985		27,475	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.27%

D. Indicate the number of paid bed-hold days the SLF had during this year 398 **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 [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* 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: 1/1/2020 Ending: 12/31/2020**

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	151,179	190,428	3,733	345,340		345,340	1
2	Housekeeping, Laundry and Maintenance	157,609	50,433	79,702	287,744	4,421	292,165	2
3	Heat and Other Utilities			78,992	78,992		78,992	3
4	Other (specify): Scavenger			17,323	17,323		17,323	4
5	**TOTAL General Services**	308,788	240,861	179,750	729,399	4,421	733,820	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	1,405,458	31,147	53,270	1,489,875		1,489,875	6
7	Activities and Social Services	39,739	964	7,360	48,063		48,063	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	1,445,197	32,111	60,630	1,537,938		1,537,938	9
	C. General Administration							
10	Administrative and Clerical	122,274	16,411	448,943	587,628	(58,671)	528,957	10
11	Marketing Materials, Promotions and Advertising		3,658	21,461	25,119		25,119	11
12	Employee Benefits and Payroll Taxes	291,112			291,112		291,112	12
13	Insurance-Property, Liability and Malpractice	20,002			20,002	10,609	30,611	13
14	Other (specify):							14
15	**TOTAL General Administration**	433,388	20,069	470,404	923,861	(48,062)	875,799	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	2,187,373	293,041	710,784	3,191,198	(43,641)	3,147,557	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					239,834	239,834	17
18	Interest					256,409	256,409	18
19	Real Estate Taxes					51,225	51,225	19
20	Rent -- Facility and Grounds			592,999	592,999	(592,999)		20
21	Rent -- Equipment							21
22	Other (specify): Mortgage insurance					47,323	47,323	22
23	**TOTAL Ownership**			592,999	592,999	1,792	594,791	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	2,187,373	293,041	1,303,783	3,784,197	(41,849)	3,742,348	24

Facility Name: Asbury Gardens Memory Care Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	8	32.06	2
3	Certified Nurse Assistants	28	15.47	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	1	11.61	10
11	Laundry			11
12	Managers	1	41.73	12
13	Other Administrative	1	13.70	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	39	$	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
Asbury Court	Des Plaines	Asbury Healthcare	Lincolnwood	Management
Asbury of Kankakee	Kankakee	EJR Enterprises	North Aurora	Property
Asbury Gardens Nursing and Rehab	North Aurora			
Asbury Court Nursing & Rehabilitation	Des Plaines			

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 [X]
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 [X] 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: 1/1/2020 Ending: 12/31/2020

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: 1/1/2020 Ending: 2/31/2020

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:** 1/1/2020 **Ending:** 12/31/2020

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,077,410	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 73,281)	687,775		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,612		6
7	Other Prepaid Expenses	989		7
8	Accounts Receivable (owners or related parties)	258,011		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,061,797	$	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)**	$ 3,061,797	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 247,154	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	48,388		30
31	Accrued Taxes Payable	4,417		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes	70,000		34
	Other Current Liabilities(specify):			
35	Management Fee Payable	79,476		35
36	Entrance Fee Payable	74,920		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 524,355	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	652,300		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)**	$ 652,300	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 1,176,655	$	45
46	**TOTAL EQUITY**	$ 1,885,142	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 3,061,797	$	47

***(See instructions.)**

Facility Name: Asbury Gardens Memory Care **Report Period Beginning: 1/1/2020 Ending: 12/31/2020**

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	$ 4,104,540	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 4,104,540	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)**	$ 4,104,540	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	729,399	19
20	Health Care/ Personal Care	1,537,938	20
21	General Administration	923,861	21
	B. Capital Expense		
22	Ownership	592,999	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)**	$ 3,784,197	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 320,343	29
30	**Income Taxes**	$ 40,346	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 279,997	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 2,424,890	32
33	Private Pay - Net Inpatient Revenue	1,679,650	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 4,104,540	37

Pg3 C. Related Party Expenses:

Repairs	4,421
Dues/Fees	34
Bank Service Fee	31
Mortgage insurance	47,323
Professional Fees	2,902
Interest	256,409
Depreciation	239,834
Real Estate Taxes	51,225
Insurance	10,609
Total Related Party Expenses	**612,788**

Expense Adjustments:

Bad Debt	(61,638)	pg. 3 IV. 10
Interest	256,409	pg. 3 IV. 18
Repairs	4,421	pg. 3 IV. 2
Dues	34	pg. 3 IV. 10
Bank Service Fee	31	pg. 3 IV. 10
Depreciation	239,834	pg. 3 IV. 17
Real Estate Taxes	51,225	pg. 3 IV. 19
Insurance	10,609	pg. 3 IV. 13
Mortgage insurance	47,323	pg. 3 IV. 22
Rent	(592,999)	pg. 3 IV. 20
Professional Fees	2,902	pg. 3 IV. 10
Total Expense Adj.	**(41,849)**	