

		FOR BHF USE			

LL2

Supportive Living Facility

2019

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2019)

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 North Aurora 60542

County: Kane

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

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.
X 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 1/1/19 to 12/31/19 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: 1/1/19 Ending: 12/31/19

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units 10/8/19

	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	37	5,945	1
2	10	Double Unit Apartment	21	4,585	2
3		Other		4,269	3
4	20	TOTALS	58	14,799	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	4,843	778		5,621	5
6	Double Unit	7,127	1,584		8,711	6
7	Other					7
8	TOTALS	11,970	2,362		14,332	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 96.84%

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

383 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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☒ YES ☐ NO

Tax Year: 12/31/19 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.

STATE OF ILLINOIS

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Facility Name: Asbury Gardens Memory Care

Report Period Beginning:

1/1/19

Ending:

12/31/19

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	162,041	169,632	2,466	334,139		334,139	1
2	Housekeeping, Laundry and Maintenance	77,378	26,422	43,729	147,529	34,142	181,671	2
3	Heat and Other Utilities			83,264	83,264		83,264	3
4	Other (specify): Scavenger			14,788	14,788		14,788	4
5	TOTAL General Services	239,419	196,054	144,247	579,720	34,142	613,862	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	1,325,249	4,971	10,310	1,340,530		1,340,530	6
7	Activities and Social Services	7,431	5,929	6,277	19,637		19,637	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	1,332,680	10,900	16,587	1,360,167		1,360,167	9
	C. General Administration							
10	Administrative and Clerical	21,818	24,349	502,466	548,633	(188,629)	360,004	10
11	Marketing Materials, Promotions and Advertising	2,661	7,217	46,032	55,910		55,910	11
12	Employee Benefits and Payroll Taxes	157,306			157,306		157,306	12
13	Insurance-Property, Liability and Malpractice	65,858			65,858	56,831	122,689	13
14	Other (specify):							14
15	TOTAL General Administration	247,643	31,566	548,498	827,707	(131,798)	695,909	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,819,742	238,520	709,332	2,767,594	(97,656)	2,669,938	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					261,924	261,924	17
18	Interest			691	691	257,853	258,544	18
19	Real Estate Taxes					54,139	54,139	19
20	Rent -- Facility and Grounds			585,121	585,121	(585,121)		20
21	Rent -- Equipment			4,288	4,288		4,288	21
22	Other (specify):							22
23	TOTAL Ownership			590,100	590,100	(11,205)	578,895	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,819,742	238,520	1,299,432	3,357,694	(108,861)	3,248,833	24

Facility Name: Asbury Gardens Memory Care

Report Period Beginning 1/1/19 Ending: 12/31/19

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	9	30.07	2
3	Certified Nurse Assistants	25	14.83	3
4	Activity Director & Assistants	1	14.50	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	10.48	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	12.95	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	36	\$	17

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	
Asbury Gardens SNF		North Aurora	
Asbury Court SNF		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 ☒

Name of related entity: If yes, what is the value of 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).

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

OTHER RELATED BUSINESS ENTITIES

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

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: 1/1/19 Ending: 12/31/19

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	2		3	4	6		7	8	9	
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		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.

STATE OF ILLINOIS

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Facility Name: Asbury Gardens Memory Care

Report Period Beginning: 1/1/19

Ending: 12/31/19

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/19

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 484,260	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 500,459)	1,519,065		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,211		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	631,976		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,703,512	\$	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)	\$ 2,703,512	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 250,154	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	89,146		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,133		30
31	Accrued Taxes Payable	613		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes	(38,857)		34
	Other Current Liabilities(specify):			
35	See Attachment1	67,336		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 525,525	\$	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)	\$ 525,525	\$	45
46	TOTAL EQUITY	\$ 2,177,987	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,703,512	\$	47

*(See instructions.)

Facility Name: Asbury Gardens Memory Care

Report Period Beginning: 1/1/19

Ending:

12/31/19

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	\$ 3,939,372	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,939,372	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	Misc		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)	\$ 3,939,372	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	579,720	19
20	Health Care/ Personal Care	1,360,167	20
21	General Administration	827,707	21
	B. Capital Expense		
22	Ownership	590,100	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)	\$ 3,357,694	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 581,678	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 581,678	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,907,903	32
33	Private Pay - Net Inpatient Revenue	2,031,469	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,939,372	37

Pg7 Other Current Liabilities:

Management Fee	86,799
Refund Account	(25,667)
Prepaid Rent	5,487
Uncashed Checks	61
Chapel	656
	<u>67,336</u>

Pg3 C. Related Party Expenses:

Repairs	34,142
Dues/Fees	98
Amortization	31,405
Professional Fees	2,893
Interest	257,853
Depreciation	230,519
Real Estate Taxes	54,139
Insurance	56,831
Total Related Party Expenses	<u>667,880</u>

Expense Adjustments:

Bad Debt	(191,620)	pg. 3 IV. 10
Interest	257,853	pg. 3 IV. 18
Dues	98	pg. 3 IV. 10
Repairs	34,142	pg. 3 IV. 2
Depreciation	261,924	pg. 3 IV. 17
Real Estate Taxes	54,139	pg. 3 IV. 19
Insurance	56,831	pg. 3 IV. 13
Rent	(585,121)	pg. 3 IV. 20
Professional Fees	2,893	pg. 3 IV. 10
Total Expense Adj.	<u>(108,861)</u>	