

		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: 1000025

Facility Name: Asbury Gardens

Address: 210 Airport Rd North Aurora 60542

County: Kane

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

Federal Employer ID Number:

Date Current Owners were Certified: 5/5/2003

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 1/1/2020 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**

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		2		3		4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period			
1	117	Single Unit Apartment	117	42,822	1		
2	53	Double Unit Apartment	53	19,398	2		
3		Other		17,909	3		
4	170	TOTALS	170	80,129	4		

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	32,628	4,537		37,165	5
6	Double Unit	30,774	5,491		36,265	6
7	Other					7
8	TOTALS	63,402	10,028		73,430	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) **91.64%**

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

1,350 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. 657 (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

ACCUAL		MODIFIED	
		CASH*	CASH*
	X		

I. Is your fiscal year identical to your tax year? ☒ 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.

STATE OF ILLINOIS

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Facility Name: Asbury Gardens

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 1	Supplies 2	Other 3	Total 4			
	A. General Services							
1	Dietary and Food Purchase	367,566	462,994	9,077	839,637		839,637	1
2	Housekeeping, Laundry and Maintenance	379,494	122,620	193,784	695,898	10,749	706,647	2
3	Heat and Other Utilities			192,055	192,055		192,055	3
4	Other (specify):			42,118	42,118		42,118	4
5	TOTAL General Services	747,060	585,614	437,034	1,769,708	10,749	1,780,457	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	2,097,195	75,730	129,518	2,302,443		2,302,443	6
7	Activities and Social Services	96,620	2,344	17,894	116,858		116,858	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	2,193,815	78,074	147,412	2,419,301		2,419,301	9
	C. General Administration							
10	Administrative and Clerical	297,289	39,901	1,088,508	1,425,698	(142,649)	1,283,049	10
11	Marketing Materials, Promotions and Advertising		8,895	52,179	61,074		61,074	11
12	Employee Benefits and Payroll Taxes			707,791	707,791		707,791	12
13	Insurance-Property, Liability and Malpractice			48,631	48,631	25,794	74,425	13
14	Other (specify):							14
15	TOTAL General Administration	297,289	48,796	1,897,109	2,243,194	(116,855)	2,126,339	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	3,238,164	712,484	2,481,555	6,432,203	(106,106)	6,326,097	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					583,118	583,118	17
18	Interest					623,417	623,417	18
19	Real Estate Taxes					124,546	124,546	19
20	Rent -- Facility and Grounds			1,441,781	1,441,781	(1,441,781)		20
21	Rent -- Equipment							21
22	Other (specify): Mortgage insurance					115,058	115,058	22
23	TOTAL Ownership			1,441,781	1,441,781	4,358	1,446,139	23
24	GRAND TOTAL (Sum of lines 16 and 23)	3,238,164	712,484	3,923,336	7,873,984	(101,748)	7,772,236	24

Facility Name: Asbury Gardens

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	13	\$ 32.09	2
3	Certified Nurse Assistants	39	15.72	3
4	Activity Director & Assistants	3	14.87	4
5	Social Service Workers			5
6	Head Cook		17.09	6
7	Cook Helpers/Assistants	6	18.94	7
8	Dishwashers	9	12.56	8
9	Maintenance Workers	4	21.14	9
10	Housekeepers	7	13.75	10
11	Laundry		10.04	11
12	Managers	1	41.73	12
13	Other Administrative	6	18.98	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	88	\$	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 Nursing and Rehab	North Aurora
Asbury Court Nursing & Rehabilitation	Des Plaines

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
Asbury Healthcare	Lincolnwood	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).

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

Facility Name: Asbury Gardens

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

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**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 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

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

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.)

1			
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 9,979,523	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 9,979,523	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	300	8
9	Non-Resident Meals	2,123	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 2,423	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	2,040	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,040	14
	D. Other Revenue (specify):		
15	COVID-19 Stimulus Income	355,940	15
16	Miscellaneous Income	7,510	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 363,450	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 10,347,436	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,769,708	19
20	Health Care/ Personal Care	2,419,301	20
21	General Administration	2,243,194	21
	B. Capital Expense		
22	Ownership	1,441,781	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)	\$ 7,873,984	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 2,473,452	29
30	Income Taxes	\$ 98,094	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 2,375,358	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 5,558,172	32
33	Private Pay - Net Inpatient Revenue	4,421,351	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 9,979,523	37

Pg3 C. Related Party Expenses:

Repairs	10,749
Dues/Fees	83
Bank Service Fee	75
Mortgage insurance	115,058
Professional Fees	7,055
Interest	623,417
Depreciation	583,118
Real Estate Taxes	124,546
Insurance	25,794
Total Related Party Expenses	<u>1,489,895</u>

Expense Adjustments:

Bad Debt	(149,862)	pg. 3 IV. 10
Interest	623,417	pg. 3 IV. 18
Repairs	10,749	pg. 3 IV. 2
Dues	83	pg. 3 IV. 10
Bank Service Fee	75	pg. 3 IV. 10
Depreciation	583,118	pg. 3 IV. 17
Real Estate Taxes	124,546	pg. 3 IV. 19
Insurance	25,794	pg. 3 IV. 13
Mortgage insurance	115,058	pg. 3 IV. 22
Rent	(1,441,781)	pg. 3 IV. 20
Professional Fees	7,055	pg. 3 IV. 10
Total Expense Adj.	<u>(101,748)</u>	