

		FOR BHF USE			

LL2

Supportive Living Facility

2010

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2010)

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: 1000021

Facility Name: Asbury Court

Address: 1750 South Elmhurst Road Des Plaines 60018

Number City Zip Code

County: Cook

Telephone Number: (847) 228-1500 Fax # (847) 228-1579

Federal Employer ID Number:

Date Current Owners were Certified: 2/28/03

Type of Ownership:

☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☐	Corporation	☐	Other
		☒	"Sub-S" Corp.		
		☐	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 1/1/10 to 12/31/10 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)	4/29/2011
	(Type or Print Name)	Michael Zahtz
	(Title)	Corporate Officer
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		

Report Period Beginning: 1/1/10 **Ending:** 12/31/10

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES ☐ NO ☒

YES ☒ NO ☐

H. ACCOUNTING BASIS

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

*** All facilities other than governmental must report on the accrual basis.**

If no, explain.

If no, explain.

If no, explain.

352 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. 171 **(Do not include bed-hold days in Section B.)**

Facility Name: Asbury Court

Report Period Beginning:

1/1/10

Ending:

12/31/10

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					5	6	
1	Dietary and Food Purchase	276,780	315,887	3,436	596,103		596,103	1
2	Housekeeping, Laundry and Maintenance	188,062	92,801	109,323	390,186		390,186	2
3	Heat and Other Utilities			199,492	199,492		199,492	3
4	Other (specify): Scavenger			9,097	9,097		9,097	4
5	TOTAL General Services	464,842	408,688	321,348	1,194,878		1,194,878	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	561,277	13,718	3,270	578,265		578,265	6
7	Activities and Social Services	35,648	13,389	11,519	60,556		60,556	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	596,925	27,107	14,789	638,821		638,821	9
	C. General Administration							
10	Administrative and Clerical	232,333	14,172	864,212	1,110,717		1,110,717	10
11	Marketing Materials, Promotions and Advertising	78,352	2,431	146,025	226,808		226,808	11
12	Employee Benefits and Payroll Taxes	166,277			166,277		166,277	12
13	Insurance-Property, Liability and Malpractice	63,124			63,124	13,080	76,204	13
14	Other (specify):				20,222	(20,222)		14
15	TOTAL General Administration	540,086	16,603	1,010,237	1,587,148	(7,142)	1,580,006	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,601,853	452,398	1,346,374	3,420,847	(7,142)	3,413,705	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			55,327	55,327	203,077	258,404	17
18	Interest					373,805	373,805	18
19	Real Estate Taxes					273,798	273,798	19
20	Rent -- Facility and Grounds			1,146,989	1,146,989	(1,146,989)		20
21	Rent -- Equipment			5,160	5,160		5,160	21
22	Other (specify):							22
23	TOTAL Ownership			1,207,476	1,207,476	(296,309)	911,167	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,601,853	452,398	2,553,850	4,628,323	(303,451)	4,324,872	24

Facility Name: Asbury Court

Report Period Beginning 1/1/10 Ending: 12/31/10

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 39.75	1
2	Licensed Practical Nurses	4	22.51	2
3	Certified Nurse Assistants	11	11.10	3
4	Activity Director & Assistants	1	12.00	4
5	Social Service Workers			5
6	Head Cook	1	25.37	6
7	Cook Helpers/Assistants	12	8.78	7
8	Dishwashers	1	8.25	8
9	Maintenance Workers	2	17.77	9
10	Housekeepers	6	8.93	10
11	Laundry			11
12	Managers	1	92.36	12
13	Other Administrative	4	11.38	13
14	Clerical	1	20.91	14
15	Marketing	1	26.95	15
16	Other			16
17	Total (lines 1 thru 16)	46	\$	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 Gardens	North Aurora

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
Ashley Management and Development Co.		Management Co.
Des Plaines Property LLC		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 Court

Report Period Beginning:

1/1/10

Ending:

12/31/10

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
6	Improvement Type										
6	See Attached 2										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 Court

Report Period Beginning: 1/1/10

Ending: 12/31/10

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.

Facility Name: Asbury Court

Report Period Beginning: 1/1/10

Ending:

12/31/10

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 645,039	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	349,210		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	55,400		7
8	Accounts Receivable (owners or related parties)	733,273		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,782,922	\$	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	1,785,612		15
16	Equipment, at Historical Cost	271,006		16
17	Accumulated Depreciation (book methods)	(1,069,942)		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)	\$ 986,676	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,769,598	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 105,380	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	381,983		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,631		30
31	Accrued Taxes Payable	20,423		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Prepaid Rent	69,339		35
36	Accrued Sick and Vacation	24,869		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 634,625	\$	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)	\$ 634,625	\$	45
46	TOTAL EQUITY	\$ 2,134,973	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,769,598	\$	47

*(See instructions.)

Facility Name: Asbury Court

Report Period Beginning: 1/1/10

Ending: 12/31/10

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 4,474,867	1
2	Discounts and Allowances		2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 4,474,867	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
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$	14
	D. Other Revenue (specify):		
15			15
16			16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 4,474,867	18

		2	
	Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,194,878	19
20	Health Care/ Personal Care	638,821	20
21	General Administration	1,580,006	21
	B. Capital Expense		
22	Ownership	911,167	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 4,324,872	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ 149,995	29
	Income Taxes		
30		\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ 149,995	31

487,445.15	273,798
665,489.47	373,805
23,286.00	13,080
347,737	195,324
1,523,958	856,007

(12,803.00)
(197)
(1,236.00)
(5,986)
(20,222) pg. 3 IV. 14

7,753	pg. 3 IV. 17
273,798	pg. 3 IV. 19
13,080	pg. 3 IV. 13
373,805	pg. 3 IV. 18
195,324	pg. 3 IV. 17
(1,146,989)	pg. 3 IV. 20
(283,229)	
(303,451)	