

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: 1000025

Facility Name: Asbury Gardens

Address: 210 Airport Rd. North Aurora 60542

Number City Zip Code

County: Kane

Telephone Number: (630) 896-7778 Fax # (630) 896-6759

Federal Employer ID Number:

Date Current Owners were Certified: 5/5/03

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		

Facility Name **Asbury Gardens**

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

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	107	Single Unit Apartment	107	39,055	1
2	43	Double Unit Apartment	43	15,695	2
3		Other			3
4	150	TOTALS	150	54,750	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	25,609	10,497		36,106	5
6	Double Unit	9,165	2,505		11,670	6
7	Other					7
8	TOTALS	34,774	13,002		47,776	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.)	87.26%
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D. Indicate the number of paid bed-hold days the SLF had during this year
305 Also, indicate the number of unpaid bed-hold days the SLF
 had during this year. 85 **(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: 12/31/10 **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

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	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	194,188	301,048	76,863	572,099		572,099	1
2	Housekeeping, Laundry and Maintenance	262,691	95,659	234,202	592,552		592,552	2
3	Heat and Other Utilities			262,844	262,844		262,844	3
4	Other (specify): Scavenger			11,497	11,497		11,497	4
5	TOTAL General Services	456,879	396,707	585,406	1,438,992		1,438,992	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	409,177	7,440	5,625	422,242		422,242	6
7	Activities and Social Services	45,261	17,131	13,369	75,761		75,761	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	454,438	24,571	18,994	498,003		498,003	9
	C. General Administration							
10	Administrative and Clerical	215,586	16,886	1,188,831	1,421,303		1,421,303	10
11	Marketing Materials, Promotions and Advertising	71,880	632	102,375	174,887		174,887	11
12	Employee Benefits and Payroll Taxes	187,273			187,273		187,273	12
13	Insurance-Property, Liability and Malpractice	40,032			40,032	33,129	73,161	13
14	Other (specify):				104,860	(104,860)		14
15	TOTAL General Administration	514,771	17,518	1,291,206	1,928,355	(71,731)	1,856,624	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,426,088	438,796	1,895,606	3,865,350	(71,731)	3,793,619	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			14,637	14,637	486,766	501,403	17
18	Interest			11,163	11,163	450,161	461,324	18
19	Real Estate Taxes					60,511	60,511	19
20	Rent -- Facility and Grounds			763,198	763,198	(763,198)		20
21	Rent -- Equipment			16,798	16,798		16,798	21
22	Other (specify):							22
23	TOTAL Ownership			805,796	805,796	234,240	1,040,036	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,426,088	438,796	2,701,402	4,671,146	162,509	4,833,655	24

Facility Name: Asbury Gardens

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	\$ 36.83	1
2	Licensed Practical Nurses	5	16.75	2
3	Certified Nurse Assistants	6	12.08	3
4	Activity Director & Assistants	1	16.45	4
5	Social Service Workers			5
6	Head Cook	1	20.00	6
7	Cook Helpers/Assistants	3	16.04	7
8	Dishwashers	1	11.00	8
9	Maintenance Workers	4	21.10	9
10	Housekeepers	3	10.56	10
11	Laundry			11
12	Managers	1	36.06	12
13	Other Administrative	2	23.90	13
14	Clerical	1	21.91	14
15	Marketing	2	25.32	15
16	Other			16
17	Total (lines 1 thru 16)	31	\$	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

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
Ashley Management	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: Ashley Management and Development Corp. If yes, what is the value of those services? \$ 75,000
(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:

1/1/10

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	Bathroom Improvements			2/23/2009	74,700	4,980	15	4,980		7,470	6
7	Nursing Station Improvements			4/6/2009	11,600	773	15	773		1,160	7
8	Nursing Station Furniture			5/7/2009	18,460	2,637	7	2,637		3,956	8
9	Bathroom Improvements			7/1/2010	117,950	3,931	15	3,931		3,931	9
10	Parking Lot Resurface			10/1/2010	52,500	1,750	15	1,750		1,750	10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 275,210	\$ 14,071		\$ 14,071	\$	\$ 18,267	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	\$ 7,906	\$ 565	\$ 565	\$	7	\$ 565	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 7,906	\$ 565	\$ 565	\$		\$ 565	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:1/1/10

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	MB Financial		X	Working Capital	/ /	40,193	470,986	/ /	4.2500	11,163	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 40,193	\$ 470,986			\$ 11,163	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 40,193	\$ 470,986			\$ 11,163	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

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	\$ 810,852	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	309,708		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	46,415		7
8	Accounts Receivable (owners or related parties)	375,000		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,541,975	\$	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	275,210		15
16	Equipment, at Historical Cost	7,906		16
17	Accumulated Depreciation (book methods)	(18,832)		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)	\$ 264,284	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,806,259	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 121,541	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	227,311		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	17,861		30
31	Accrued Taxes Payable	3,797		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Due to Affiliates	565,471		35
36	Line of Credit	470,986		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,406,967	\$	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)	\$ 1,406,967	\$	45
46	TOTAL EQUITY	\$ 399,292	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,806,259	\$	47

*(See instructions.)

Facility Name: Asbury Gardens

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	\$ 4,716,113	1
2	Discounts and Allowances		2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 4,716,113	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)	\$ 4,716,113	18

		2	
	Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,438,992	19
20	Health Care/ Personal Care	498,003	20
21	General Administration	1,856,624	21
	B. Capital Expense		
22	Ownership	1,040,036	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)	\$ 4,833,655	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ (117,542)	29
	Income Taxes		
30		\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ (117,542)	31

(675.00)
4.09
(95,811.00)
(735.00)
(6,800.00)
(843.00)
\$ (104,859.91) pg. 3 IV. 14

450,161 pg. 3 IV. 18
486,766 pg. 3 IV. 17
60,511 pg. 3 IV. 19
33,129 pg. 3 IV. 13
(763,198.00) pg. 3 IV. 20
\$ 267,369.00

\$ 162,509.09

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450,161 pg. 3 IV. 18
486,766 pg. 3 IV. 17
60,511 pg. 3 IV. 19
33,129 pg. 3 IV. 13
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Parent Co.:

75,000
75,000 pg. 4, VII. B