

		FOR BHF USE			

LL2

Supportive Living Facility

2014

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2014)

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 # (630) 896-6759

Federal Employer ID Number:

Date Current Owners were Certified: 5/5/03

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> 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 1/1/14 to 12/31/14 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: 1/1/14 Ending: 12/31/14**

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	10	Single Unit Apartment	10	3,650	1		
2	10	Double Unit Apartment	10	3,650	2		
3		Other		3,264	3		
4	20	TOTALS	20	10,564	4		

B. Census-For the entire report period.

	1 Type of Unit	2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	2,396			2,396	5
6	Double Unit	6,527	7		6,534	6
7	Other					7
8	TOTALS	8,923	7		8,930	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) **84.53%**

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

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

ACCUAL		MODIFIED	
CASH*	<input type="checkbox"/>	CASH*	<input type="checkbox"/>

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

Tax Year: 12/31/14 **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.

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Facility Name: Asbury Gardens Memory Care

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	46,471	75,993	5,832	128,296		128,296	1
2	Housekeeping, Laundry and Maintenance	29,358	24,686	60,042	114,086		114,086	2
3	Heat and Other Utilities			34,505	34,505		34,505	3
4	Other (specify): Scavenger			3,240	3,240		3,240	4
5	TOTAL General Services	75,829	100,679	103,619	280,127		280,127	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	372,556	2,306	17,538	392,400		392,400	6
7	Activities and Social Services	45,831	8,166	185	54,182		54,182	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	418,387	10,472	17,723	446,582		446,582	9
	C. General Administration							
10	Administrative and Clerical	43,372	11,339	505,089	559,800	2,183	561,983	10
11	Marketing Materials, Promotions and Advertising	5,804	22	16,969	22,795		22,795	11
12	Employee Benefits and Payroll Taxes	100,925			100,925		100,925	12
13	Insurance-Property, Liability and Malpractice	12,163			12,163	7,803	19,966	13
14	Other (specify):							14
15	TOTAL General Administration	162,264	11,361	522,058	695,683	9,986	705,669	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	656,480	122,512	643,400	1,422,392	9,986	1,432,378	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					149,380	149,380	17
18	Interest					178,804	178,804	18
19	Real Estate Taxes					12,902	12,902	19
20	Rent -- Facility and Grounds			199,960	199,960	(199,960)		20
21	Rent -- Equipment			22	22		22	21
22	Other (specify):							22
23	TOTAL Ownership			199,982	199,982	141,126	341,108	23
24	GRAND TOTAL (Sum of lines 16 and 23)	656,480	122,512	843,382	1,622,374	151,112	1,773,486	24

Facility Name: Asbury Gardens Memory Care

Report Period Beginning 1/1/14 Ending: 12/31/14

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 32.94	1
2	Licensed Practical Nurses	1	23.67	2
3	Certified Nurse Assistants	6	12.02	3
4	Activity Director & Assistants	1	22.62	4
5	Social Service Workers			5
6	Head Cook	0	38.57	6
7	Cook Helpers/Assistants	0	11.77	7
8	Dishwashers	0	10.91	8
9	Maintenance Workers	0	23.40	9
10	Housekeepers	0	9.82	10
11	Laundry			11
12	Managers	0	150.75	12
13	Other Administrative	0	19.52	13
14	Clerical	0	36.35	14
15	Marketing	0	46.55	15
16	Other			16
17	Total (lines 1 thru 16)	10	\$	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: _____ 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

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1/1/14

Ending:

12/31/14

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

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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	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.

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 248,386	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,624,583		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	35,449		7
8	Accounts Receivable (owners or related parties)	1,420,256		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,328,674	\$	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)	\$ 3,328,674	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 178,938	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	130,821		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,201		30
31	Accrued Taxes Payable	(146)		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	863,678		35
36	Prepaid Rent	48,706		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,297,198	\$	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)	\$ 1,297,198	\$	45
46	TOTAL EQUITY	\$ 2,031,476	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 3,328,674	\$	47

*(See instructions.)

Facility Name: Asbury Gardens Memory Care

Report Period Beginning: 1/1/14

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12/31/14

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

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,406,386	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,406,386	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)	\$ 1,406,386	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	280,127	19
20	Health Care/ Personal Care	446,582	20
21	General Administration	695,683	21
	B. Capital Expense		
22	Ownership	199,982	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)	\$ 1,622,374	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (215,988)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (215,988)	31

Expense Adjustments:

Interest	178,804	pg. 3 IV. 18
Depreciation	149,380	pg. 3 IV. 17
Real Estate Taxes	12,902	pg. 3 IV. 19
Insurance	7,803	pg. 3 IV. 13
Rent	(199,960)	pg. 3 IV. 20
Professional Fees	2,183	pg. 3 IV. 10
Total Expense Adj.	151,112	

Related Party Expenses:

Interest	178,804	pg. 3 IV. 18
Depreciation	149,380	pg. 3 IV. 17
Real Estate Taxes	12,902	pg. 3 IV. 19
Insurance	7,803	pg. 3 IV. 13
Professional Fees	2,183	pg. 3 IV. 10
Total Related Party Expenses	351,072	

