

		FOR BHF USE			

LL2

Supportive Living Facility

2015

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2015)

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

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:

<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 1/1/15 to 12/31/15 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: 1/1/15 Ending: 12/31/15**

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		3,635	3		
4	20	TOTALS	20	10,935	4		

B. Census-For the entire report period.

	1 Type of Unit	2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
Resident Days by Unit and Primary Source of Payment						
5	Single Unit	2,575	433		3,008	5
6	Double Unit	6,112	1,157		7,269	6
7	Other					7
8	TOTALS	8,687	1,590		10,277	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.98%

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

153 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. **15 (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	
	<input checked="" type="checkbox"/>	CASH*	<input type="checkbox"/>
		CASH*	<input type="checkbox"/>

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

Tax Year: 12/31/15 **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.

STATE OF ILLINOIS

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Facility Name: Asbury Gardens Memory Care

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	40,769	10,132	6,947	57,848		57,848	1
2	Housekeeping, Laundry and Maintenance	44,388	26,183	44,592	115,163		115,163	2
3	Heat and Other Utilities			38,476	38,476		38,476	3
4	Other (specify): Scavenger			3,631	3,631		3,631	4
5	TOTAL General Services	85,157	36,315	93,646	215,118		215,118	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	774,011	362	13,218	787,591		787,591	6
7	Activities and Social Services	59,483	10,359	1,551	71,393		71,393	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	833,494	10,721	14,769	858,984		858,984	9
	C. General Administration							
10	Administrative and Clerical	34,299	4,149	156,217	194,665	16,125	210,790	10
11	Marketing Materials, Promotions and Advertising	15,459	1,579	5,790	22,828		22,828	11
12	Employee Benefits and Payroll Taxes	119,730			119,730		119,730	12
13	Insurance-Property, Liability and Malpractice	10,227			10,227	6,490	16,717	13
14	Other (specify):							14
15	TOTAL General Administration	179,715	5,728	162,007	347,450	22,615	370,065	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,098,366	52,764	270,422	1,421,552	22,615	1,444,167	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					148,387	148,387	17
18	Interest					152,821	152,821	18
19	Real Estate Taxes					13,627	13,627	19
20	Rent -- Facility and Grounds			246,744	246,744	(246,744)		20
21	Rent -- Equipment			79	79		79	21
22	Other (specify):							22
23	TOTAL Ownership			246,823	246,823	68,091	314,914	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,098,366	52,764	517,245	1,668,375	90,706	1,759,081	24

Facility Name: Asbury Gardens Memory Care

Report Period Beginning 1/1/15 Ending: 12/31/15

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 27.57	1
2	Licensed Practical Nurses	2	25.82	2
3	Certified Nurse Assistants	10	11.81	3
4	Activity Director & Assistants	1	15.56	4
5	Social Service Workers			5
6	Head Cook	0	34.38	6
7	Cook Helpers/Assistants	1	10.85	7
8	Dishwashers	0	10.62	8
9	Maintenance Workers	1	24.86	9
10	Housekeepers	0	9.96	10
11	Laundry			11
12	Managers	0	45.00	12
13	Other Administrative	1	16.23	13
14	Clerical	0	28.00	14
15	Marketing	0	31.34	15
16	Other			16
17	Total (lines 1 thru 16)	19	\$	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
Asbury Healthcare	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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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 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.

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 382,263	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 41,500)	1,057,346		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,183		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,778,910		8
9	Other(specify): Clearing Acct	7,183		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,268,885	\$	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)	\$ 3,268,885	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 342,061	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,770		30
31	Accrued Taxes Payable	1,052		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes	22,250		34
	Other Current Liabilities(specify):			
35	Prepaid Rent	5,487		35
36	Management Fee Payable	(2,143)		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 467,477	\$	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	Entrance Fee Payable	112,887		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 112,887	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 580,364	\$	45
46	TOTAL EQUITY	\$ 2,688,521	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 3,268,885	\$	47

*(See instructions.)

Facility Name: Asbury Gardens Memory Care

Report Period Beginning: 1/1/15

Ending:

12/31/15

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	\$ 1,412,168	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,412,168	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)	\$ 1,412,168	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	215,118	19
20	Health Care/ Personal Care	858,984	20
21	General Administration	370,065	21
	B. Capital Expense		
22	Ownership	314,914	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)	\$ 1,759,081	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (346,913)	29
30	Income Taxes	\$ 4,069	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (350,982)	31

Expense Adjustments:

Interest	152,821	pg. 3 IV. 18
Depreciation	148,387	pg. 3 IV. 17
Real Estate Taxes	13,627	pg. 3 IV. 19
Insurance	6,490	pg. 3 IV. 13
Rent	(246,744)	pg. 3 IV. 20
Professional Fees	926	pg. 3 IV. 10
Other Fees	2	pg. 3 IV. 10
Bank Fees	15,196	pg. 3 IV. 10
Total Expense Adj.	90,706	

Related Party Expenses:

Amortization	5,068.40	pg. 3 IV. 17
Other Fees	2.00	pg. 3 IV. 10
Professional Fees	926.27	pg. 3 IV. 10
Interest	152,821.16	pg. 3 IV. 18
Depreciation	143,318.32	pg. 3 IV. 17
Real Estate Taxes	13,627.21	pg. 3 IV. 19
Insurance	6,490.23	pg. 3 IV. 13
Bank Fees	15,196.03	pg. 3 IV. 10
Total Related Party Expenses	337,450	