

		FOR BHF USE			

LL2

Supportive Living Facility

2016

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2016)

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 S Elmhurst Road Des Plaines 60018

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
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 1/1/16 to 12/31/16 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 Court**

Report Period Beginning: 1/1/16 Ending: 12/31/16

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	121	Single Unit Apartment	121	44,165	1		
2	29	Double Unit Apartment	29	10,585	2		
3		Other		9,931	3		
4	150	TOTALS	150	64,681	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	42,172	953		43,125	5
6	Double Unit	18,823	734		19,557	6
7	Other					7
8	TOTALS	60,995	1,687		62,682	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.)	96.91%
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D. Indicate the number of paid bed-hold days the SLF had during this year

895 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. **23 (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*	☐

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

Tax Year: 12/31/16 **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 Court

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	307,284	39,124	352,424	698,832		698,832	1
2	Housekeeping, Laundry and Maintenance	301,710	100,565	141,534	543,809		543,809	2
3	Heat and Other Utilities			213,322	213,322		213,322	3
4	Other (specify): Scavenger			25,171	25,171		25,171	4
5	TOTAL General Services	608,994	139,689	732,451	1,481,134		1,481,134	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	508,064	15,090	23,816	546,970		546,970	6
7	Activities and Social Services	34,066	12,135		46,201		46,201	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	542,130	27,225	23,816	593,171		593,171	9
	C. General Administration							
10	Administrative and Clerical	293,993	29,114	734,690	1,057,797	41,717	1,099,514	10
11	Marketing Materials, Promotions and Advertising	81,058	5,520	38,149	124,727		124,727	11
12	Employee Benefits and Payroll Taxes	177,193			177,193		177,193	12
13	Insurance-Property, Liability and Malpractice	117,738			117,738	40,276	158,014	13
14	Other (specify):							14
15	TOTAL General Administration	669,982	34,634	772,839	1,477,455	81,993	1,559,448	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,821,106	201,548	1,529,106	3,551,760	81,993	3,633,753	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			103,455	103,455	416,253	519,708	17
18	Interest					487,670	487,670	18
19	Real Estate Taxes					482,747	482,747	19
20	Rent -- Facility and Grounds			1,273,062	1,273,062	(1,273,062)		20
21	Rent -- Equipment			2,671	2,671		2,671	21
22	Other (specify):							22
23	TOTAL Ownership			1,379,188	1,379,188	113,608	1,492,796	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,821,106	201,548	2,908,294	4,930,948	195,601	5,126,549	24

Facility Name: Asbury Court

Report Period Beginning 1/1/16 Ending: 12/31/16

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 41.93	1
2	Licensed Practical Nurses	4	29.53	2
3	Certified Nurse Assistants	10	13.15	3
4	Activity Director & Assistants	1	18.22	4
5	Social Service Workers			5
6	Head Cook	1	29.44	6
7	Cook Helpers/Assistants	13	10.46	7
8	Dishwashers	3	10.07	8
9	Maintenance Workers	3	28.66	9
10	Housekeepers	10	11.78	10
11	Laundry			11
12	Managers	1	79.98	12
13	Other Administrative	7	12.25	13
14	Clerical	1	23.11	14
15	Marketing	1	34.54	15
16	Other			16
17	Total (lines 1 thru 16)	58	\$	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	
Asbury Gardens Nursing and Rehab		North Aurora	

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

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Des Plaines Property LLC				Property	
Asbury Healthcare				Management Co.	

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: Asbury Healthcare If yes, what is the value of those services? \$99,538.15
(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).

Facility Name: Asbury Court Report Period Beginning: 1/1/16 Ending: 12/31/16

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	See Attachment3										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: 1/1/16 Ending: 12/31/16

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.

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Facility Name: Asbury Court

Report Period Beginning: 1/1/16

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,754,662	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	1,707,468		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,971		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(5,133,272)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,385,829	\$	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	3,240,993		15
16	Equipment, at Historical Cost	404,921		16
17	Accumulated Depreciation (book methods)	(1,808,271)		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)	\$ 1,837,643	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,223,472	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 255,300	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	109,127		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,914		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes	40,000		34
	Other Current Liabilities(specify):			
35	Management Fee Payable	107,101		35
36	Accrued Expenses	78,746		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 693,188	\$	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)	\$ 693,188	\$	45
46	TOTAL EQUITY	\$ 6,530,284	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,223,472	\$	47

*(See instructions.)

Facility Name: Asbury Court

Report Period Beginning: 1/1/16

Ending:

12/31/16

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	\$ 6,441,578	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 6,441,578	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)	\$ 6,441,578	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,481,134	19
20	Health Care/ Personal Care	593,171	20
21	General Administration	1,559,448	21
	B. Capital Expense		
22	Ownership	1,492,796	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)	\$ 5,126,549	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 1,315,029	29
30	Income Taxes	\$ 36,168	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 1,278,861	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 4,219,415	32
33	Private Pay - Net Inpatient Revenue	2,222,163	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 6,441,578	37

Related Party Expenses

VII. B.

Description	Amount
Accounting, Billing, Payroll Services	99,538.15

VII. C.

Description	Amount
Property Taxes	482,747.00
Insurance	40,276.00
Depreciation	488,976.00
Interest	487,670.00
Other Fees	22,584.00
Amortization Expense	30,732.00
Professional Fees	19,133.00
Total Related Party Expenses	<u>1,572,118</u>

Expenses Adjustments:

Other Fees	22,584	pg. 3 IV. 10
Professional Fees	19,133	pg. 3 IV. 10
Depreciation adj.	(103,455.00)	pg. 3 IV. 17
Amortization Expense	30,732.00	pg. 3 IV. 17
Property taxes	482,747.00	pg. 3 IV. 19
Insurance	40,276.00	pg. 3 IV. 13
Interest	487,670.00	pg. 3 IV. 18
Depreciation	488,976.00	pg. 3 IV. 17
Rent	(1,273,062)	pg. 3 IV. 20
Total Adjustments	<u>195,601</u>	

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