

		FOR BHF USE			

LL2

Supportive Living Facility

**2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2013)**

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.

<p>I. Facility ID Number: <u>100X025</u></p> <p>Facility Name: <u>Asbury Gardens Memory Care</u></p> <p>Address: <u>210 Airport Road</u> <u>North Aurora</u> <u>60542</u> <small>Number City Zip Code</small></p> <p>County: <u>Kane</u></p> <p>Telephone Number: (<u>630</u>) <u>896-7778</u> Fax # (<u>630</u>) <u>896-6759</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>5/5/03</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael Zahtz</u> Telephone Number: (<u>847</u>) <u>676-1700</u> Email Address: _____</p>	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/13</u> to <u>12/31/13</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>Michael Zahtz</u> (Title) <u>CFO</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Michael Zahtz</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name Asbury Gardens Memory Care

Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units 9/11/11

	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		3,348	3
4	20	TOTALS	20	10,648	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	1,977	1,650		3,627	5
6	Double Unit	5,618	1,079		6,697	6
7	Other					7
8	TOTALS	7,595	2,729		10,324	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.96%

D. Indicate the number of paid bed-hold days the SLF had during this year 116 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 4 (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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ 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 Memory Care

Report Period Beginning:

01/01/13

Ending:

12/31/13

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		76,766	766	77,532		77,532	1
2	Housekeeping, Laundry and Maintenance	30,780	24,147	55,703	110,630		110,630	2
3	Heat and Other Utilities			41,746	41,746		41,746	3
4	Other (specify): Waste Removal			3,416	3,416		3,416	4
5	TOTAL General Services	30,780	100,913	101,631	233,324		233,324	5
B. Health Care and Programs								
6	Health Care/ Personal Care	346,785	575	469	347,829		347,829	6
7	Activities and Social Services	44,605	7,483	174	52,262		52,262	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	391,390	8,058	643	400,091		400,091	9
C. General Administration								
10	Administrative and Clerical	38,202	11,482	303,299	352,983	7,056	360,039	10
11	Marketing Materials, Promotions and Advertising	12,056	160	19,568	31,784		31,784	11
12	Employee Benefits and Payroll Taxes	74,636			74,636		74,636	12
13	Insurance-Property, Liability and Malpractice	11,265			11,265	5,381	16,646	13
14	Other (specify):							14
15	TOTAL General Administration	136,159	11,642	322,867	470,668	12,437	483,105	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	558,329	120,613	425,141	1,104,083	12,437	1,116,520	16
Capital Expenses								
D. Ownership								
17	Depreciation					101,986	101,986	17
18	Interest					136,637	136,637	18
19	Real Estate Taxes					12,049	12,049	19
20	Rent -- Facility and Grounds			297,098	297,098	(297,098)		20
21	Rent -- Equipment			944	944		944	21
22	Other (specify):							22
23	TOTAL Ownership			298,042	298,042	(46,426)	251,616	23
24	GRAND TOTAL (Sum of lines 16 and 23)	558,329	120,613	723,183	1,402,125	(33,989)	1,368,136	24

Facility Name: Asbury Gardens Memory Care

Report Period Beginning 01/01/13

Ending: 12/31/13

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 33.40	1
2	Licensed Practical Nurses	2	23.26	2
3	Certified Nurse Assistants	10	10.44	3
4	Activity Director & Assistants	1	15.53	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers	0	21.94	9
10	Housekeepers	0	8.83	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	0	24.69	14
15	Marketing	0	29.51	15
16	Other			16
17	Total (lines 1 thru 16)	16	\$	17

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

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).

Facility Name: Asbury Gardens Memory Care

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

Facility Name: Asbury Gardens Memory Care

Report Period Beginning: 01/01/13

Ending: 12/31/13

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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			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 Gardens Memory Care

Report Period Beginning: 01/01/13

Ending:

12/31/13

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,347,050	\$	1
2	Cash-Patient Deposits	117,601		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance \$41,500)	1,111,221		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,579		6
7	Other Prepaid Expenses	2,030		7
8	Accounts Receivable (owners or related parties)	175,909		8
9	Other(specify): Clearing Account	4,549		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,787,939	\$	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)	\$ 2,787,939	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 331,663	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	171,268		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,215		30
31	Accrued Taxes Payable	12,273		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes	6,000		34
	Other Current Liabilities(specify):			
35	Accrued Dividends Payable	1,200		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 577,619	\$	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)	\$ 577,619	\$	45
46	TOTAL EQUITY	\$ 2,210,320	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,787,939	\$	47

*(See instructions.)

Facility Name: Asbury Gardens Memory Care

Report Period Beginning: 01/01/13

Ending:

12/31/13

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	\$ 1,411,094	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,411,094	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)	\$ 1,411,094	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	233,324	19
20	Health Care/ Personal Care	400,091	20
21	General Administration	470,668	21
B. Capital Expense			
22	Ownership	298,042	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)	\$ 1,402,125	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 8,969	29
30	Income Taxes	\$ 1,065	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 7,904	31

Expense Adjustments:

Interest	136,637	pg. 3 IV. 18
Depreciation	101,986	pg. 3 IV. 17
Real Estate Taxes	12,049	pg. 3 IV. 19
Insurance	5,381	pg. 3 IV. 13
Rent	(297,098)	pg. 3 IV. 20
Professional Fees	1,988	pg. 3 IV. 10
Bank Fees	5,068	pg. 3 IV. 10
Total Expense Adj.	<u>(33,989)</u>	

Related Party Expenses:

Interest	136,637	pg. 3 IV. 18
Depreciation	101,986	pg. 3 IV. 17
Real Estate Taxes	12,049	pg. 3 IV. 19
Insurance	5,381	pg. 3 IV. 13
Professional Fees	1,988	pg. 3 IV. 10
Bank Fees	5,068	pg. 3 IV. 10
Total Related Party Expenses	<u>263,109</u>	

