

		FOR BHF USE			

LL2

Supportive Living Facility
2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2005)

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.</p> <p>Facility Name: <u>Asbury Gardens</u></p> <hr/> <p>Address: <u>210 Airport Rd</u> <u>North Aurora</u> <u>60542</u> Number City Zip Code</p> <p>County: <u>Kane County</u></p> <p>Telephone Number: <u>(630) 896-7778</u> Fax # <u>(630) 896-6759</u></p> <p>Federal Employer ID Number: <u>391563524</u></p> <p>Date Current Owners were Certified: <u>5/5/2003</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael Zahtz</u> Telephone Number: <u>(630) 264-3818</u></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 checked="" type="checkbox"/> "Sub-S" Corp.			<input 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>1/1/05</u> to <u>12/31/05</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%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Michael Zahtz</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>Accountant</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>()</u> _____</td> <td style="border: none;">Fax # () _____</td> </tr> </table> <p align="center">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) _____	(Date) _____		(Type or Print Name) <u>Michael Zahtz</u>			(Title) <u>Accountant</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) <u>()</u> _____	Fax # () _____
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Facility Name Asbury Gardens

Report Period Beginning: 1/1/05 Ending: 12/31/05

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	106	Single Unit Apartment	106	38,690	1
2	44	Double Unit Apartment	44	16,060	2
3		Other		3,650	3
4	150	TOTALS	150	58,400	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	22,346	10,984		33,330	5
6	Double Unit	11,170	5,721		16,891	6
7	Other					7
8	TOTALS	33,516	16,705		50,221	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 85.99%

D. Indicate the number of paid bed-hold days the SLF had during this year 339 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 121 (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

Report Period Beginning:

1/1/05

Ending:

12/31/05

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	207,135	231,958	3,431	442,524		442,524	1
2	Housekeeping, Laundry and Maintenance	135,708	39,525	109,013	284,245		284,245	2
3	Heat and Other Utilities			203,302	203,302		203,302	3
4	Other (specify): Waste Management			7,210	7,210		7,210	4
5	TOTAL General Services	342,842	271,483	322,956	937,281		937,281	5
B. Health Care and Programs								
6	Health Care/ Personal Care	612,030	7,262	4,092	623,383		623,383	6
7	Activities and Social Services	36,409	12,572	7,637	56,618		56,618	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	648,439	19,834	11,729	680,002		680,002	9
C. General Administration								
10	Administrative and Clerical	126,369	17,684	127,160	271,214		271,214	10
11	Marketing Materials, Promotions and Advertising	58,144	4,380	118,072	180,595		180,595	11
12	Employee Benefits and Payroll Taxes	202,716			202,716		202,716	12
13	Insurance-Property, Liability and Malpractice	115,370			115,370		115,370	13
14	Other (specify):							14
15	TOTAL General Administration	502,599	22,064	245,232	769,895		769,895	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,493,879	313,381	579,917	2,387,177		2,387,177	16
Capital Expenses								
D. Ownership								
17	Depreciation			418,042	418,042	(63,251)	354,791	17
18	Interest			525,928	525,928		525,928	18
19	Real Estate Taxes			132,912	132,912		132,912	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			1,076,883	1,076,883	(63,251)	1,013,631	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,493,879	313,381	1,656,800	3,464,060	(63,251)	3,400,809	24

Facility Name: Asbury Gardens

Report Period Beginning 1/1/05 Ending: 12/31/05

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 27.28	1
2	Licensed Practical Nurses	4	22.57	2
3	Certified Nurse Assistants	9	11.13	3
4	Activity Director & Assistants	2	18.25	4
5	Social Service Workers			5
6	Head Cook	1	21.86	6
7	Cook Helpers/Assistants	9	8.21	7
8	Dishwashers	1	7.75	8
9	Maintenance Workers	3	14.58	9
10	Housekeepers	4	8.92	10
11	Laundry			11
12	Managers	1	52.08	12
13	Other Administrative	3	10.10	13
14	Clerical	1	19.53	14
15	Marketing	1	16.41	15
16	Other			16
17	Total (lines 1 thru 16)	41	\$	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 <u>1</u>	City <u>2</u>
Asbury Court	Des Plaines

OTHER RELATED BUSINESS ENTITIES

Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
Asbury Towers	North Aurora	Retirement

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

Report Period Beginning: 1/1/05

Ending: 12/31/05

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 Attachment 1										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

Report Period Beginning: 1/1/05

Ending: 12/31/05

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	Key Bank Real Estate Capital		X	Property Mortgage	10/14/98	\$ 8,900,000	\$ 8,071,754	11/1/08	6.7800	\$ 525,928
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 8,900,000	\$ 8,071,754			\$ 525,928
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 8,900,000	\$ 8,071,754			\$ 525,928

* 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.

STATE OF ILLINOIS

Page 7

Facility Name: **Asbury Gardens**Report Period Beginning: **1/1/05**

Ending:

12/31/05**12/31/05****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/05**

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 403,915	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	541,748		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	35,457		7
8	Accounts Receivable (owners or related parties)	1,329,495		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,310,615	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,114,671		13
14	Buildings, at Historical Cost	7,493,973		14
15	Leasehold Improvements, at Historical Cost	2,659,000		15
16	Equipment, at Historical Cost	246,771		16
17	Accumulated Depreciation (book methods)	(5,840,969)		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): Escrow	178,155		22
23	Other(specify): Goodwill	232,732		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,084,334	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,394,949	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 71,219	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	167,096		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,991		30
31	Accrued Taxes Payable	53,000		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Payroll Withholdings and Taxes	27,042		35
36	Prepaid Rent and Other	66,325		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 425,673	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	18,000		38
39	Mortgage Payable	8,071,754		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Accounts payable (owners or related parties)	166,267		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 8,256,021	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,681,695	\$	45
46	TOTAL EQUITY	\$ (286,746)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,394,949	\$	47

*(See instructions.)

Facility Name: Asbury Gardens

Report Period Beginning: 1/1/05

Ending:

12/31/05

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	\$ 3,975,299	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,975,299	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	Food Stamps	74,376	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 74,376	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,049,675	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	937,281	19
20	Health Care/ Personal Care	680,002	20
21	General Administration	769,895	21
B. Capital Expense			
22	Ownership	1,013,631	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)	\$ 3,400,809	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 648,867	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 648,867	31

