

		FOR BHF USE			

LL2

Supportive Living Facility

**2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2006)**

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> <p>Address: <u>210 Airport Rd</u> <u>North Aurora</u> <u>IL</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>896-1579</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></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td style="border: none;"><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></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>1/1/06</u> to <u>12/31/06</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 border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>Michael Zahtz</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>Accountant</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____</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 # (<u> </u>) _____
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	(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____																																						

Facility Name: Asbury Gardens

Report Period Beginning:

1/1/06

Ending:

12/31/06

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	230,910	259,490	1,300	491,700		491,700	1
2	Housekeeping, Laundry and Maintenance	173,104	121,849	270,862	565,815	(112,792)	453,023	2
3	Heat and Other Utilities			239,723	239,723		239,723	3
4	Other (specify): Waste Management			7,798	7,798		7,798	4
5	TOTAL General Services	404,014	381,339	519,683	1,305,036	(112,792)	1,192,244	5
B. Health Care and Programs								
6	Health Care/ Personal Care	600,299	10,814	26,418	637,531		637,531	6
7	Activities and Social Services	55,566	6,916	10,664	73,146		73,146	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	655,865	17,730	37,082	710,677		710,677	9
C. General Administration								
10	Administrative and Clerical	103,760	35,366	1,010,172	1,149,298	(57,779)	1,091,519	10
11	Marketing Materials, Promotions and Advertising	39,737	2,841	111,861	154,439		154,439	11
12	Employee Benefits and Payroll Taxes	183,921			183,921		183,921	12
13	Insurance-Property, Liability and Malpractice	133,600			133,600		133,600	13
14	Other (specify):			8,846	8,846	(8,846)		14
15	TOTAL General Administration	461,018	38,207	1,130,879	1,630,104	(66,625)	1,563,479	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,520,897	437,276	1,687,644	3,645,817	(179,417)	3,466,400	16
Capital Expenses								
D. Ownership								
17	Depreciation			402,761	402,761	(63,251)	339,509	17
18	Interest			542,592	542,592		542,592	18
19	Real Estate Taxes			177,434	177,434	(26,713)	150,721	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			2,502	2,502		2,502	21
22	Other (specify):							22
23	TOTAL Ownership			1,125,289	1,125,289	(89,964)	1,035,324	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,520,897	437,276	2,812,933	4,771,106	(269,381)	4,501,724	24

Facility Name: Asbury Gardens

Report Period Beginning 1/1/06 Ending: 12/31/06

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 26.08	1
2	Licensed Practical Nurses	6	23.00	2
3	Certified Nurse Assistants	9	11.85	3
4	Activity Director & Assistants	2	16.83	4
5	Social Service Workers			5
6	Head Cook	1	21.88	6
7	Cook Helpers/Assistants	8	8.64	7
8	Dishwashers	1	8.25	8
9	Maintenance Workers	3	21.40	9
10	Housekeepers	3	9.75	10
11	Laundry			11
12	Managers	1	36.06	12
13	Other Administrative	3	10.84	13
14	Clerical	1	19.79	14
15	Marketing	1	20.83	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	1	City	2
Asbury Court		Des Plaines	
Asbury Towers		North Aurora	
Moraine Court		Bridgeview	
Tinley Court		Tinley Park	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Ashley Management and Development		Chicago		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: Ashley Management and Development Co. If yes, what is the value of those services? \$ 75,000

(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: 1/1/06

Ending: 12/31/06

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 Attachment1										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	\$ See Attachment1	\$	\$	\$		\$	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: 1/1/06

Ending: 12/31/06

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	\$ 7,919,512	11/1/08	6.7800	\$ 542,592
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 8,900,000	\$ 7,919,512			\$ 542,592
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 8,900,000	\$ 7,919,512			\$ 542,592

* 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

Facility Name: Asbury Gardens

Report Period Beginning: 1/1/06

Ending:

Page 7

12/31/06

12/31/06

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

	1	2	
	Operating	After	
		Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 52,169	\$ 1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	853,475	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	37,255	7
8	Accounts Receivable (owners or related parties)	1,362,983	8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,305,882	\$ 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	2,816,383	15
16	Equipment, at Historical Cost	260,727	16
17	Accumulated Depreciation (book methods)	(6,180,478)	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)	\$ 5,916,163	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,222,045	\$ 25

	1	2	
	Operating	After	
		Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 95,171	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	187,798	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	39,499	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	25,031	35
36	Accrued Sick and Vacation	10,422	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 410,921	\$ 37
D. Long-Term Liabilities			
38	Long-Term Notes Payable	18,000	38
39	Mortgage Payable	7,919,512	39
40	Bonds Payable		40
41	Deferred Compensation		41
Other Long-Term Liabilities(specify):			
42	Accounts payable (owners or related parties)	199,755	42
43			43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 8,137,267	\$ 44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,548,188	\$ 45
46	TOTAL EQUITY	\$ (326,143)	\$ 46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,222,045	\$ 47

*(See instructions.)

Facility Name: Asbury Gardens

Report Period Beginning: 1/1/06

Ending:

12/31/06

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

	1	Amount	
	Revenue		
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 4,505,200	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,505,200	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)	\$ 4,505,200	18

	2	Amount	
	Expenses		
	A. Operating Expenses		
19	General Services	1,192,244	19
20	Health Care/ Personal Care	710,677	20
21	General Administration	1,563,479	21
	B. Capital Expense		
22	Ownership	1,035,324	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)	\$ 4,501,724	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 3,476	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 3,476	31

Other Non-Allowable Expenses from pg 3:

Reconciliation Discrepancies	94
Writeoff	8,659
Bank Service Charges	<u>93</u>
	<u>\$ 8,846.21</u> pg. 3, line 14

Services Received from a Parent Co.:

Administrators Salary	75,000.00
Accounting Fees	<u>15,000.00</u>
	<u>\$ 90,000.00</u>

