

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2007  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2007)**

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><b>I.</b></p> <p>Facility Name: <u>Asbury Court North</u></p> <hr/> <p>Address: <u>1750 Elmhurst Rd</u> <u>Des Plaines</u> <u>60018</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>( 847 ) 228-1500</u> Fax # <u>(847 ) 228-1579</u></p> <p>Federal Employer ID Number: <u>36-3985189</u></p> <p>Date Current Owners were Certified: <u>2/28/2003</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 <u>          </u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other <u>          </u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" 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 <u>          </u></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>(847 ) 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 <u>          </u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u>          </u>		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u>          </u>		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/07</u> to <u>12/31/07</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 align="center">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 &amp; Address) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) (    ) _____ Fax # (    ) _____</td> <td style="border: none;"></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) _____	(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) (    ) _____ Fax # (    ) _____	
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Facility Name: Asbury Court North

Report Period Beginning:

1/1/07

Ending:

12/31/07

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	245,420	317,535	34,165	597,120		597,120	1
2	Housekeeping, Laundry and Maintenance	180,116	78,828	97,127	356,071	(6,308)	349,763	2
3	Heat and Other Utilities			195,453	195,453		195,453	3
4	Other (specify):			6,199	6,199		6,199	4
5	<b>TOTAL General Services</b>	<b>425,536</b>	<b>396,363</b>	<b>332,944</b>	<b>1,154,843</b>	<b>(6,308)</b>	<b>1,148,535</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	621,721	11,055	11,724	644,500		644,500	6
7	Activities and Social Services	45,988	4,751	22,862	73,601		73,601	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>667,709</b>	<b>15,806</b>	<b>34,586</b>	<b>718,101</b>		<b>718,101</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	199,927	12,918	999,278	1,212,123		1,212,123	10
11	Marketing Materials, Promotions and Advertising	78,708	6,731	105,290	190,729		190,729	11
12	Employee Benefits and Payroll Taxes	159,744			159,744		159,744	12
13	Insurance-Property, Liability and Malpractice	58,322			58,322		58,322	13
14	Other (specify):	27,112			27,112	(27,112)		14
15	<b>TOTAL General Administration</b>	<b>523,813</b>	<b>19,649</b>	<b>1,104,568</b>	<b>1,648,030</b>	<b>(27,112)</b>	<b>1,620,918</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,617,058</b>	<b>431,818</b>	<b>1,472,098</b>	<b>3,520,974</b>	<b>(33,420)</b>	<b>3,487,554</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			356,702	356,702	(55,314)	301,388	17
18	Interest			374,418	374,418		374,418	18
19	Real Estate Taxes			181,355	181,355		181,355	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			300	300		300	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>912,775</b>	<b>912,775</b>	<b>(55,314)</b>	<b>857,461</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,617,058</b>	<b>431,818</b>	<b>2,384,873</b>	<b>4,433,749</b>	<b>(88,734)</b>	<b>4,345,015</b>	<b>24</b>

Facility Name: Asbury Court North

Report Period Beginning: 1/1/07 Ending: 12/31/07

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 36.48	1
2	Licensed Practical Nurses	4	23.89	2
3	Certified Nurse Assistants	13	11.20	3
4	Activity Director & Assistants	2	12.76	4
5	Social Service Workers			5
6	Head Cook	1	23.08	6
7	Cook Helpers/Assistants	8	8.61	7
8	Dishwashers	2	7.79	8
9	Maintenance Workers	3	15.01	9
10	Housekeepers	4	10.21	10
11	Laundry			11
12	Managers	1		12
13	Other Administrative	3	12.47	13
14	Clerical	1	14.12	14
15	Marketing	2	22.64	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>45</b>	<b>\$</b>	<b>17</b>

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
<b>Total</b>				<b>\$</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$</b>
		<b>3</b>

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 Gardens	North Aurora
Moraine Court	Bridgeview
Tinley Court	Tinley Park

OTHER RELATED BUSINESS ENTITIES

Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
Ashley Management and Development	Chicago	Management Co.
Des Plaines Property LLC	Des Plaines	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 Court North

Report Period Beginning: 1/1/07

Ending: 12/31/07

**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
<b>Improvement Type</b>											
6	See Attachment 2										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	See Attachment 2	\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: Asbury Court North

Report Period Beginning: 1/1/07

Ending: 12/31/07

**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	<b>TOTAL</b>				\$			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**	YES			NO	Amount of Note				
							Original					
		<b>A. Directly Facility Related</b>										
		<b>Long-Term</b>										
1						/ /	\$		/ /		\$	1
2						/ /			/ /			2
3						/ /			/ /			3
		<b>Working Capital</b>										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		<b>TOTAL Facility Related</b>					\$	\$			\$	7
		<b>B. Non-Facility Related</b>										
8						/ /			/ /			8
9						/ /			/ /			9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$	\$			\$	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.

## STATE OF ILLINOIS

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Facility Name: Asbury Court North

Report Period Beginning: 1/1/07

Ending:

12/31/07

12/31/07

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 140,718	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	948,817		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	30,394		7
8	Accounts Receivable (owners or related parties)	412,311		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,532,240	\$	10
	<b>B. Long-Term Assets</b>			
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	1,634,821		15
16	Equipment, at Historical Cost	241,145		16
17	Accumulated Depreciation (book methods)	(524,589)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,351,377	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,883,617	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 96,602	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	385,401		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,791		30
31	Accrued Taxes Payable	35,062		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	Prepaid Rental Income	40,259		35
36	Accrued Sick and Vacation	34,293		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 678,408	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42	Other Current Liability	50		42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 50	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 678,458	\$	45
46	<b>TOTAL EQUITY</b>	\$ 2,205,159	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 2,883,617	\$	47

\*(See instructions.)

Facility Name: Asbury Court North

Report Period Beginning: 1/1/07

Ending:

12/31/07

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 4,106,753	1
2	Discounts and Allowances		2
<b>SUBTOTAL Resident Care</b>			
3	(line 1 minus line 2)	\$ 4,106,753	3
<b>B. Other Operating Revenue</b>			
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
<b>SUBTOTAL OTHER OPERATING REVENUE</b>			
11	(sum of lines 4 thru 10)	\$	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
<b>SUBTOTAL Non-Operating Revenue</b>			
14	(sum of lines 12 and 13)	\$	14
<b>D. Other Revenue (specify):</b>			
15			15
16			16
<b>SUBTOTAL Other Revenue</b>			
17	(sum of lines 15 and 16)	\$	17
<b>TOTAL REVENUE</b>			
18	(sum of lines 3, 11, 14 and 17)	\$ 4,106,753	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	1,148,535	19
20	Health Care/ Personal Care	718,101	20
21	General Administration	1,620,918	21
<b>B. Capital Expense</b>			
22	Ownership	857,461	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
<b>TOTAL EXPENSES</b>			
28	(sum of lines 19 thru 27)	\$ 4,345,015	28
<b>Income Before Income Taxes</b>			
29	(line 18 minus line 28)	\$ (238,262)	29
<b>Income Taxes</b>			
30		\$	30
<b>NET INCOME OR LOSS FOR THE YEAR</b>			
31	(line 29 minus line 30)	\$ (238,262)	31

### Related Party Expenses

Description	Amount	SLF Share of Expenses	
Property taxes	345,900	181,355.00	pg. 3 IV. 19
Interest	714,129	374,418.00	pg. 3 IV. 18
Depreciation	372,019	195,050.00	pg. 3 IV. 17
	<u>1,432,047.66</u>	<u>750,823.00</u>	

### Unallowed Expenses:

Bad Debt Expense	19,658.29	
State Taxes	6,980.74	
Bank Rec. Discrepancy	480.30	
Bank Service Charges	(7.79)	
	<u>27,111.54</u>	pg. 3 IV. 14
Assets to be depreciated	6,308	pg. 3 IV. 2
Depreciation adj	<u>55,314.00</u>	pg. 3 IV. 17
Total Adjustments	<u>88,734</u>	



Account	Debit	Credit	Balance
1000 Cash		1000	1000
1010 Accounts Receivable	1000		1000
1020 Inventory		1000	1000
1030 Prepaid Insurance		1000	1000
1040 Equipment		1000	1000
1050 Accumulated Depreciation			
2000 Accounts Payable		1000	1000
2010 Notes Payable		1000	1000
2020 Unearned Revenue		1000	1000
3000 Common Stock		1000	1000
3010 Retained Earnings		1000	1000
4000 Sales		1000	1000
4010 Sales Discounts	1000		1000
4020 Sales Tax Payable		1000	1000
4030 Cost of Sales	1000		1000
5000 Advertising Expense	1000		1000
5010 Insurance Expense	1000		1000
5020 Depreciation Expense	1000		1000
5030 Interest Expense	1000		1000
5040 Income Tax Expense	1000		1000
5050 Dividend Expense	1000		1000
6000 Net Income		1000	1000
6010 Net Loss	1000		1000
7000 Total	5000	5000	