FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051193

Facility Name: Asbury Gardens Nrsg & Rehab

Address: 212 Airport Road (Number) North Aurora (City) 60542 (Zip Code)

County: Kane

Telephone Number: (630) 896-7778 **Fax #** (630) 896-6759

HFS ID Number:

Date of Initial License for Current Owners: 02/20/2014

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/2016 to 12/31/2016 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	75	Skilled (SNF)	75	27,450	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,450	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,593	1,219	7,952	11,764	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,593	1,219	7,952	11,764	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 42.86%

D. How many bed-hold days during this year were paid by the Department?
N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/23/14

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New Construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 75 and days of care provided 4,623

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	157,951	17,142	9,338	184,431		184,431		184,431			1
2	Food Purchase		58,136		58,136		58,136		58,136			2
3	Housekeeping	75,924	5,783	232	81,939		81,939		81,939			3
4	Laundry			55,074	55,074		55,074		55,074			4
5	Heat and Other Utilities			68,886	68,886		68,886		68,886			5
6	Maintenance	73,519	30,221	65,566	169,306		169,306	(31,993)	137,313			6
7	Other (specify):*											7
8	TOTAL General Services	307,394	111,282	199,096	617,772		617,772	(31,993)	585,779			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	979,560	76,400	276,569	1,332,529		1,332,529		1,332,529			10
10a	Therapy											10a
11	Activities											11
12	Social Services	118,726	1,987	4,287	125,000		125,000		125,000			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,098,286	78,387	280,856	1,457,529		1,457,529		1,457,529			16
	C. General Administration											
17	Administrative	136,730		319,312	456,042		456,042	(319,312)	136,730			17
18	Directors Fees											18
19	Professional Services			126,058	126,058		126,058	9,593	135,651			19
20	Dues, Fees, Subscriptions & Promotions			36,099	36,099		36,099	(84)	36,015			20
21	Clerical & General Office Expenses	119,463	19,918	9,332	148,713		148,713	34,038	182,751			21
22	Employee Benefits & Payroll Taxes			182,204	182,204		182,204		182,204			22
23	Inservice Training & Education											23
24	Travel and Seminar			125	125		125	110	235			24
25	Other Admin. Staff Transportation							4,009	4,009			25
26	Insurance-Prop.Liab.Malpractice			14,223	14,223		14,223	8,013	22,236			26
27	Other (specify):* Mgmt. Co. Benefits							228	228			27
28	TOTAL General Administration	256,193	19,918	687,353	963,464		963,464	(263,405)	700,059			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,661,873	209,587	1,167,305	3,038,765		3,038,765	(295,398)	2,743,367			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Asbury Gardens Nrsg & Rehab #0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							229,950	229,950			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							152,712	152,712			32
33	Real Estate Taxes							48,712	48,712			33
34	Rent-Facility & Grounds			312,000	312,000		312,000	(309,304)	2,696			34
35	Rent-Equipment & Vehicles			54,801	54,801		54,801		54,801			35
36	Other (specify):* HUD MIP Expense							5,333	5,333			36
37	TOTAL Ownership			366,801	366,801		366,801	127,403	494,204			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		271,784	554,306	826,090		826,090		826,090			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,566	66,566		66,566		66,566			42
43	Other (specify):* Non-Allowable Cos	131,642		112,888	244,530		244,530	(244,530)				43
44	TOTAL Special Cost Centers	131,642	271,784	733,760	1,137,186		1,137,186	(244,530)	892,656			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,793,515	481,371	2,267,866	4,542,752		4,542,752	(412,525)	4,130,227			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	94,605	30		9
10	Interest and Other Investment Income	(738)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,165)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(59,045)	43		24
25	Fund Raising, Advertising and Promotional	(20,188)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(279)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(171,331)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (159,141)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(253,384)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (253,384)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (412,525)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Asbury Gardens Nrsg & Rehab

ID# 0051193

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salaries	$ (131,642)	43	1
2	Labs - Part A	(19,740)	43	2
3	X-Rays - Part A	(7,831)	43	3
4	Wound Care	(66)	43	4
5	Consolidated Billing	(6,018)	43	5
6	Offset Misc. Income	(2,417)	21	6
7	Adjust Real Estate Taxes	28,376	33	7
8	Capitalizing R&M >$2,500	(31,993)	6	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(171,331)		49

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Abraham Diamond	16.6667	N/A		Asbury Court LLC	Des Plaines	Ind & Asst Liv; SLF
Moshe Kahn	16.6667			Asbury Healthcare	Skokie	Management Co.
Shoshana Kahn	16.6667			Asbury Gardens	North Aurora	Supportive Living
Samuel Seleski	16.6667			SLF, LLC		Facility
Rachel Diamond	16.6667			Des Plaines	Des Plaines	Real Estate
Miriam Seleski	16.6667			Property, LLC		
				EJR Enterprises, Inc.	Skokie	Real Estate

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	$	EJR Enterprises, Inc.	60%	$ 11,143	$ 11,143	1
2	V	20	Dues and Subscriptions		EJR Enterprises, Inc.	60%	88	88	2
3	V	21	Miscellaneous		EJR Enterprises, Inc.	60%	30	30	3
4	V	21	Office Supplies		EJR Enterprises, Inc.	60%	26	26	4
5	V	26	Property Insurance Exp		EJR Enterprises, Inc.	60%	7,123	7,123	5
6	V	32	Amortization Expense		EJR Enterprises, Inc.	60%	11,971	11,971	6
7	V	30	Depreciation Expense		EJR Enterprises, Inc.	60%	135,345	135,345	7
8	V	32	Closing Costs		EJR Enterprises, Inc.	60%	2,596	2,596	8
9	V	32	Interest: Capital One Loan		EJR Enterprises, Inc.	60%	63,429	63,429	9
10	V	32	Interest: SNF Loan Int Exp	3,037	EJR Enterprises, Inc.	60%	78,491	75,454	10
11	V	36	HUD MIP Expense		EJR Enterprises, Inc.	60%	5,333	5,333	11
12	V	33	Taxes - Property		EJR Enterprises, Inc.	60%	20,336	20,336	12
13	V	34	Rent	312,000	EJR Enterprises, Inc.	60%		(312,000)	13
14	Total			$ 315,037			$ 335,911	$ * 20,874	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 182,946	Asbury Gardens SLF, LLC	60%	$ 182,946	$	15
16	V	2	Food	58,136	Asbury Gardens SLF, LLC	60%	58,136		16
17	V	3	Housekeeping	15,098	Asbury Gardens SLF, LLC	60%	15,098		17
18	V	5	Utilities	68,886	Asbury Gardens SLF, LLC	60%	68,886		18
19	V	6	Repairs & Maintenance	105,385	Asbury Gardens SLF, LLC	60%	105,385		19
20	V	10	Nursing	2,718	Asbury Gardens SLF, LLC	60%	2,718		20
21	V	10	Clinical Director	(23,608)	Asbury Gardens SLF, LLC	60%	(23,608)		21
22	V	12	Social Services	14,155	Asbury Gardens SLF, LLC	60%	14,155		22
23	V	17	Administrator	7,939	Asbury Gardens SLF, LLC	60%	7,939		23
24	V	20	Dues and Subscriptions	252	Asbury Gardens SLF, LLC	60%	252		24
25	V	21	Office Expense	7,532	Asbury Gardens SLF, LLC	60%	7,532		25
26	V	43	Advertising	37,754	Asbury Gardens SLF, LLC	60%	37,754		26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 477,193			$ 477,193	$ * 0	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 319,312	Asbury Healthcare	60%	$	$ (319,312)	15
16	V	19	Professional Fees		Asbury Healthcare	60%	615	615	16
17	V	20	Licenses & Permits		Asbury Healthcare	60%	28	28	17
18	V	20	Dues, Fees, & Subscriptions		Asbury Healthcare	60%	(200)	(200)	18
19	V	21	Administrative Salaries	77,477	Asbury Healthcare	60%	109,889	32,412	19
20	V	21	Office Supplies		Asbury Healthcare	60%	3,987	3,987	20
21	V	24	Travel Expense		Asbury Healthcare	60%	110	110	21
22	V	25	Auto Expense		Asbury Healthcare	60%	4,009	4,009	22
23	V	26	Insurance		Asbury Healthcare	60%	890	890	23
24	V	27	Mgmt. Alloc. - EE Benefits (Health)		Asbury Healthcare	60%	6	6	24
25	V	27	Mgmt. Alloc. - EE Benefits (W/C)		Asbury Healthcare	60%	222	222	25
26	V	34	Rent Expense		Asbury Healthcare	60%	2,696	2,696	26
27	V	43	State Taxes		Asbury Healthcare	60%	279	279	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 396,789			$ 122,531	$ * (274,258)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2		Note : No owners received compensation from this facility.									2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Asbury Gardens SLF, LLC
Street Address: 210 Airport Road
City / State / Zip Code: North Aurora, IL 60542
Phone Number: (630) 896-7778
Fax Number: (630) 896-6759

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Sal, Supplies & Taxes	Direct	1	1	$ 182,408	$ 150,456	1	$ 182,408	1
2	1	Dietary Equip Rental & R&M	Total Beds / Units	298	2	2,130		75	536	2
3	2	Food	Direct	1	1	58,136		1	58,136	3
4	3	Housekeeping Salaries & Taxes	Direct	1	1	14,214	12,921	1	14,214	4
5	3	Housekeeping Supplies	Total Beds / Units	298	2	3,515		75	885	5
6	5	Utilities	Total Beds / Units	298	2	273,709		75	68,886	6
7	6	Maintenance Salaries & Taxes	Direct	1	1	77,820	70,746	1	77,820	7
8	6	Maintenance Supplies & Others	Total Beds / Units	298	2	109,525		75	27,565	8
9	10	Nursing Salaries & Taxes	Direct	1	1	2,718	2,471	1	2,718	9
10	10	Clinical Director Salaries & Taxes	Direct	1	1	(23,608)	(21,462)	1	(23,608)	10
11	12	Activities & Social Services	Direct	1	1	11,989	10,899	1	14,155	11
12	17	Admin Salaries & Taxes	Direct	1	1	7,939	7,217	1	7,939	12
13	20	Permits, Dues and Subscriptions	Total Beds / Units	298	2	1,000		75	252	13
14	21	Campus Office Expense	Direct	1	1	156		1	156	14
15	21	Admin Office Expense	Total Beds / Units	298	2	29,309		75	7,376	15
16	43	Marketing Salaries & Taxes	Direct	1	1	32,798	29,816	1	32,798	16
17	43	Advertising	Total Beds / Units	298	2	19,694		75	4,957	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 803,450	$ 263,065		$ 477,193	25

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Asbury Healthcare
Street Address: 7040 N. Ridgeway Ave.
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 676-1700
Fax Number: (847) 675-1700

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Bed Days Available	245,586	3	$ 5,506	$	27,450	$ 615	1
2	20	Licenses & Permits	Bed Days Available	245,586	3	250		27,450	28	2
3	20	Dues, Fees, & Subscriptions	Bed Days Available	245,586	3	(1,785)		27,450	(200)	3
4	21	Administrative Salaries	Bed Days Available	245,586	3	983,157		27,450	109,889	4
5	21	Office Supplies	Bed Days Available	245,586	3	35,667		27,450	3,987	5
6	24	Travel Expense	Bed Days Available	245,586	3	987		27,450	110	6
7	25	Auto Expense	Bed Days Available	245,586	3	35,864		27,450	4,009	7
8	26	Insurance	Bed Days Available	245,586	3	7,961		27,450	890	8
9	27	Mgmt. Alloc. - EE Benefits (Health	Bed Days Available	245,586	3	55		27,450	6	9
10	27	Mgmt. Alloc. - EE Benefits (W/C)	Bed Days Available	245,586	3	1,989		27,450	222	10
11	34	Rent Expense	Bed Days Available	245,586	3	24,123		27,450	2,696	11
12	43	State Taxes	Bed Days Available	245,586	3	2,500		27,450	279	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,096,274	$		$ 122,531	25

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X	Construction / Mortgage	25,275.32	03/19/13	$ 4,135,000	$	06/15/16	0.0428	$ 78,491	1
2	Capital One HUD Loan		X	Construction / Mortgage	23,119.75	06/01/16	3,863,128	3,839,104	07/01/51	0.0342	63,429	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$48,395.07		$ 7,998,128	$ 3,839,104			$ 141,920	9
	B. Non-Facility Related*											
10								Allocated from RE Entity - Amortization			11,971	10
11								Allocated from RE Entity - Closing Costs			2,596	11
12								Interest Income			(3,775)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 10,792	14
15	TOTALS (line 9+line14)						$ 7,998,128	$ 3,839,104			$ 152,712	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 5,333 Line # 36

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$	1
	2015		
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 48,712	2
3. Under or (over) accrual (line 2 minus line 1).		$ 48,712	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 48,712	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012	8,025	9
2013	8,940	10
2014	17,387	11
2015	48,712	12

Facility does not accrue real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** **This denial must be no more than four years old at the time the cost report is filed.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Asbury Pavilion Nursing and Rehabilitation Center, LLC COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0051193

CONTACT PERSON REGARDING THIS REPORT Michael Zahtz

TELEPHONE (847) 676-1700 FAX #: (847) 675-1700

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-04-451-010	Skilled Nursing Facility	$ 48,711.80	$ 48,711.80
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 48,711.80	$ 48,711.80

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Asbury Gardens Supportive Living - 107 Single Unit Apartments; 43 Double Unit Apartments

Asbury Gardens Supportive Living (Memory Care) - 10 Single Unit Apartments; 10 Double Unit Apartments

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	56,241	1986	$ 189,466	1
2					2
3	TOTALS	56,241		$ 189,466	3

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	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	
4	75			2013	$ 4,760,004	$	40	$ 119,000	$ 119,000	$ 297,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Utility Building - Hot Water, Data, Telephone & Electrical			2010	168,592		40	4,215	4,215	27,396	9
10											10
11	Excavate & Install new Sidewalk - West Side of Building			2014	3,800		15	253	253	633	11
12											12
13	Patch, prime & paint walls around AC units outside; replace 5 locks			2015	2,750		15	183	183	275	13
14	Relocate main water line and sprinkler in nursing home			2015	6,900		15	460	460	690	14
15											15
16	Installation of digital television capabilities throughout facility			2015	15,381		15	1,025	1,025	1,538	16
17	Install shelves to the walls and wiring										17
18											18
19	R/M Reclass - Plumbing: HydroJett Sewer Service; Root Intrusion			2015	12,080		15	805	805	1,208	19
20											20
21	R/M Reclass - Install indoor/outdoor keypad locks & programming			2015	3,898		15	260	260	390	21
22	with alarm system - Nursing & Rehabilitation wing - 212 Building doors										22
23											23
24	R/M Reclass - Circuit room Battery Replacement - 2 8D Batteries			2015	2,784		5	557	557	835	24
25											25
26	R/M Reclass - Mechanical repairs to rooftop units; modified roof ductwor			2015	17,673		15	1,178	1,178	1,767	26
27											27
28	R/M Reclass - Repair to RTU electrical room, replaced ignition board,			2015	3,055		15	204	204	306	28
29	Washed coils, repaired disconnected heat and power										29
30											30
31	Dining Room - Install back wall, install paneling and corner guards			2015	6,420		15	428	428	642	31
32	Relocate electrical and water line for new equipment										32
33											33
34	Electrical Room - Installed one Energy meter for the ATS, install wire			2015	2,560		15	171	171	256	34
35	mounting wardware										35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Patient Wander Guard System Installation throughout Facility	2016	$ 18,466	$	10	$ 923	$ 923	$ 923	37
38									38
39	R/M Reclass: Plumbing and Sewer Repair in Rooms 301, 302 and	2016	3,310		20	83	83	83	39
40									40
41	R/M Reclass: Tempering Valve above Heater Replacement in	2016	3,528		10	176	176	176	41
42	Mechanical Room								42
43									43
44	R/M Reclass: Laundry Room Upgrades - Permit, Architectural	2016	25,155		20	629	629	629	44
45	Drawing, HVAC, Water Line, Gas Line, Plumbing, Electrical,								45
46	Concrete, Exterior Reframing, Interior Walls, Floor, Ceiling,								46
47	Doors and Hardware								47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,056,356	$ -		$ 130,550	$ 130,550	$ 335,247	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 496,996	$	$ 99,399	$ 99,399	5	$ 244,075	71
72	Current Year Purchases				-			72
73	Fully Depreciated Assets				-			73
74					-			74
75	TOTALS	$ 496,996	$ -	$ 99,399	$ 99,399		$ 244,075	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			$	$ -	$ -	$ -		$	76
77					-	-	-			77
78					-	-	-			78
79					-	-	-			79
80	TOTALS			$ -	$ -	$ -	$ -		$ -	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,742,818	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 229,950	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 229,950	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 579,322	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Leased from a Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Management Company				2,696			6
7	TOTAL				$ 2,696 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 54,801 Description: See Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name: **Asbury Gardens Nrsg & Rehab**
IDPH License ID Number: **0051193**
Fiscal Year End: **12/31/2016**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	4,319
Knife	94
Nursing Equipment	29,872
Therapy Equipment	20,516
Total - Line 16	**54,801**

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L39(2)(3)	hrs	$	3,076	$ 198,732	$ (420)	3,076	$ 198,312	1
2	Licensed Speech and Language Development Therapist	L39(2)(3)	hrs		1,757	111,799	(236)	1,757	111,563	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39(2)(3)	hrs		3,661	237,447	(501)	3,661	236,946	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39(2)	# of prescrpts				260,100		260,100	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39(2)					12,841		12,841	12
13	Other (specify): Ambulance	L39(3)				6,328			6,328	13
14	TOTAL			$	8,493	$ 554,306	$ 271,784	8,493	$ 826,090	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Asbury Gardens Nrsg & Rehab **#** 0051193 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 24,038	$ 24,038	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	1,225,937	1,225,937	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,548	5,548	7
8	Accounts Receivable (owners or related parties)	120,601	120,601	8
9	Other(specify): See Sch. 17A	184,205	184,205	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,560,329	$ 1,560,329	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		189,466	13
14	Buildings, at Historical Cost		4,760,004	14
15	Leasehold Improvements, at Historical Cost		296,352	15
16	Equipment, at Historical Cost		496,996	16
17	Accumulated Depreciation (book methods)		(579,322)	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)**	$	$ 5,163,496	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,560,329	$ 6,723,825	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 105,006	$ 105,006	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,509	74,509	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	4,095,505	4,095,505	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,275,020	$ 4,275,020	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,839,104	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,839,104	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,275,020	$ 8,114,124	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,714,691)	$ (1,390,299)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,560,329	$ 6,723,825	48

***(See instructions.)**

Facility Name: **Asbury Gardens Nrsg & Rehab**
IDPH License ID Number: **0051193**
Fiscal Year End: **12/31/2016**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Acct. No.	Description	Operating	After Consolidation
1260	Exchange Clearing Account	38	38
1550	Medicare Settlement	183,131	183,131
1560-00	Medicaid Settlement	1,036	1,036
	Total - Line 9	**184,205**	**184,205**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Acct. No.	Description	Operating	After Consolidation
2050	Due to Asbury Gardens	2,606,512	2,606,512
2051	Management Fee Payable	534,446	534,446
2052	Rent Payable	624,000	624,000
2060	Due to Asbury Court	258,706	258,706
2061	Due to Asbury Healthcare	28,765	28,765
2250	Refunds Due/Clearing Account	5,114	5,114
2406	Payroll Liabilities: Health Insurance V	2,080	2,080
2407	Payroll Liabilities: Dental Insurance V	438	438
2408	Payroll Liabilities: Supplemental Insu	(37)	(37)
2500	Due to Ashley Management	35,481	35,481
	Total - Line 36	**4,095,505**	**4,095,505**

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,163,344)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,163,344)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(551,351)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	4	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (551,347)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,714,691)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,944,429	1
2	Discounts and Allowances for all Levels	(54,754)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,889,675	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	98,499	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 98,499	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	12	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	60	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 72	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	738	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 738	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	2,417	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,417	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,991,401	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	617,772	31
32	Health Care	1,457,529	32
33	General Administration	963,464	33
	B. Capital Expense		
34	Ownership	366,801	34
	C. Ancillary Expense		
35	Special Cost Centers	1,070,620	35
36	Provider Participation Fee	66,566	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,542,752	40
41	**Income before Income Taxes (line 30 minus line 40)****	(551,351)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (551,351)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 762,294	44
45	Private Pay - Net Inpatient Revenue	339,353	45
46	Medicare - Net Inpatient Revenue	2,288,979	46
47	Other-(specify) Managed Care	452,928	47
48	Other-(specify) Medicaid Pending	46,121	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,889,675	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A^ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

^ - This entity is a Cash Basis Tax Payer

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,826	2,149	$ 92,922	$ 43.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,367	15,725	460,901	29.31	3
4	Licensed Practical Nurses	1,966	2,313	61,090	26.41	4
5	CNAs & Orderlies	18,294	21,522	310,645	14.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	4,679	5,504	118,726	21.57	11
12	Dietician					12
13	Food Service Supervisor	642	756	22,364	29.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,443	12,286	135,587	11.04	15
16	Dishwashers					16
17	Maintenance Workers	2,237	2,632	73,519	27.93	17
18	Housekeepers	6,492	7,638	75,924	9.94	18
19	Laundry					19
20	Administrator	3,121	3,672	136,730	37.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,050	3,589	119,463	33.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C‹ See Sch 20A	480	564	54,002	95.75	32
33	Other(specify) Marketing	4,309	5,070	131,642	25.96	33
34	TOTAL (lines 1 - 33)	70,906	83,420	$ 1,793,515 *	$ 21.50	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 9,072	1(3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	2,063	12(3)	45
46	Other(specify) MDS Consultant	Monthly	5,723	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 16,858		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	947	$ 49,257	10(3)	50
51	Licensed Practical Nurses	669	28,105	10(3)	51
52	Certified Nurse Assistants/Aides	8,334	183,356	10(3)	52
53	TOTAL (lines 50 - 52)	9,951	$ 260,718		53

Facility Name: **Asbury Gardens Nrsg & Rehab**
IDPH License ID Number: **0051193**
Fiscal Year End: **12/31/2016**

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Clinical Director	150	176	16,846	$ 95.72
MDS Coordinator	330	388	37,156	$ 95.76
Total - Line 32 Other Health Care (specify):	**480**	**564**	**54,002**	**$ 95.75**

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shannon Deckinga	Administrator	0	$ 71,237
Susan M Kalas	Administrator	0	15,970
Joseph E Park	Administrator	0	16,923
Christopher M Rayborn	Administrator	0	32,600
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 136,730

B. Administrative - Other

Description	Amount
Management Fees - Asbury Healthcare	$ 319,312
Eliminated in Col. 7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 319,312
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PointClickCare	Clinical Software	$ 10,164
ADP	Payroll Processing	6,223
Emdeon	Billing Software	603
ZirMed	Healthcare Mgmt Software	258
Collette Smart	Operation Consulting	60,270
Personnel Planners, Inc.	U/C Consulting	309
RSM US LLP	Accounting	10,290
IPMG Risk Management Services, In	Risk Management	1,000
Nancy Hartmann	Software Consulting	2,325
Polsinelli PC	Legal	20,222
Scott & Kraus, LLC	Legal	12,230
Chubb Group	Legal	2,165
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 126,058

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,703
Unemployment Compensation Insurance	
FICA Taxes	140,962
Employee Health Insurance	6,193
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	5,346
TOTAL (agree to Schedule V, line 22, col.8)	$ 182,204

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 500
Advertising: Employee Recruitment	21,814
Health Care Worker Background Check	
(Indicate # of checks performed 525)	6,297
Patient Background Checks 180	2,160
Miscellaneous Licenses & Fees	250
Miscellaneous Dues/Subscriptions	5,078
Allocated from Home Office	(84)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,015

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	125
Allocated from Management Company	110
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 235

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Asbury Gardens Nrsg & Rehab**
IDPH License ID Number: **0051193**
Fiscal Year End: **12/31/2016**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Professional Fees from Page 21	Various	126,058
	Total (agree to Schedule V, line 19, column 3)	126,058
Allocated from Real Estate Entity	Professional Services	11,143
Allocated from Management Company	Professional Services	615
Less: Non-Allowable Legal Fees	Retainers	(2,165)
	Total (agree to Schedule V, line 19, column 8)	135,651

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,556** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **66,566**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **-** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees