FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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: 0055012

Facility Name: Asbury Court Nursing & Rehabilitation, LLC

Address: 1750 S. Elmhurst Road (Number) Des Plaines (City) 60018 (Zip Code)

County: Cook

Telephone Number: (847) 228-1500 **Fax #** (847) 228-1579

HFS ID Number:

Date of Initial License for Current Owners: 8/16/2018

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 8/16/18 to 2/28/19 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 Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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	71	Skilled (SNF)	71	13,987	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	71	TOTALS	71	13,987	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		221	680	901	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		221	680	901	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 6.44%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 8/27/2018

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/16/2018 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 71 and days of care provided 680

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name: **Asbury Court Nursing & Rehabilitation, LLC**
IDPH License ID Number: **0055012**
Fiscal Year End: **2/28/19**

Schedule 2A

III. Statistical Data
Bed Days Computation

Licensure Level of Care	# of Beds	Start Date	End Date	# of Days	Bed Days Available
Skilled (SNF)	71	8/16/18	2/28/19	197	13,987
Skilled (SNF)					-
			Total - Line 1, Column 4		13,987

Licensure Level of Care	# of Beds	Start Date	End Date	# of Days	Bed Days Available
Intermediate (ICF)					-
Intermediate (ICF)					-
			Total - Line 3, Column 4		-

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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	8,920	1,246	1,300	11,466		11,466	-	11,466			1
2	Food Purchase		5,658		5,658		5,658	-	5,658			2
3	Housekeeping	12,921	3,347	-	16,268		16,268	-	16,268			3
4	Laundry	-	-	-				-				4
5	Heat and Other Utilities			32,399	32,399		32,399	-	32,399			5
6	Maintenance	3,935	19,314	23,328	46,577		46,577	87	46,664			6
7	Other (specify):*	-	-	-				-				7
8	**TOTAL General Services**	25,776	29,565	57,027	112,368		112,368	87	112,455			8
	B. Health Care and Programs											
9	Medical Director	-	-	-				-				9
10	Nursing and Medical Records	244,768	25,389	309	270,466		270,466	-	270,466			10
10a	Therapy	-	-	-				-				10a
11	Activities	1,875	416	2,188	4,479		4,479	-	4,479			11
12	Social Services	-	-	-				-				12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	-				-				14
15	Other (specify):*	-	-	-				-				15
16	**TOTAL Health Care and Programs**	246,643	25,805	2,497	274,945		274,945		274,945			16
	C. General Administration											
17	Administrative	52,408	-	20,728	73,136		73,136	(20,728)	52,408			17
18	Directors Fees			-				-				18
19	Professional Services			46,401	46,401		46,401	34,505	80,906			19
20	Dues, Fees, Subscriptions & Promotions			84,869	84,869		84,869	-	84,869			20
21	Clerical & General Office Expenses	-	28,340	32,505	60,845		60,845	1,100	61,945			21
22	Employee Benefits & Payroll Taxes			(11,865)	(11,865)		(11,865)	-	(11,865)			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			-				-				24
25	Other Admin. Staff Transportation		-	-				-				25
26	Insurance-Prop.Liab.Malpractice			19,395	19,395		19,395	4,114	23,509			26
27	Other (specify):*	-	-	-				-				27
28	**TOTAL General Administration**	52,408	28,340	192,033	272,781		272,781	18,991	291,772			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	324,827	83,710	251,557	660,094		660,094	19,078	679,172			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 Court Nursing & Rehabilitation, LLC #0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			-				95,487	95,487			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			-				382,392	382,392			32
33	Real Estate Taxes			-				13,990	13,990			33
34	Rent-Facility & Grounds			307,774	307,774		307,774	(307,774)				34
35	Rent-Equipment & Vehicles			6,269	6,269		6,269	-	6,269			35
36	Other (specify):* **Mortgage Ins**			-				15,109	15,109			36
37	**TOTAL Ownership**			314,043	314,043		314,043	199,204	513,247			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	35,556	74,364	109,920		109,920	-	109,920			39
40	Barber and Beauty Shops	-	-	-				-				40
41	Coffee and Gift Shops	-	-	6,167	6,167		6,167	-	6,167			41
42	Provider Participation Fee			4,546	4,546		4,546	-	4,546			42
43	Other (specify):* **Non-Allowable Cos**	22,891	-	147,491	170,382		170,382	(170,382)				43
44	**TOTAL Special Cost Centers**	22,891	35,556	232,568	291,015		291,015	(170,382)	120,633			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	347,718	119,266	798,168	1,265,152		1,265,152	47,900	1,313,052			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 Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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	(294,741)	30		9
10	Interest and Other Investment Income				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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(142,029)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(49,417)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (486,187)		$	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)	534,087		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 534,087		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 47,900		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 Court Nursing & Rehabilitation, LLC

ID# 0055012

Report Period Beginning: 8/16/18

Ending: 2/28/19

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (5,143)	43	1
2	Marketing Salaries	(22,891)	43	2
3	Credit Card Fees	(319)	43	3
4	Management Fees	(20,728)	17	4
5	Taxes	(336)	43	5
6				6
7				7
8				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
28				28
29				29
30				30
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**	(49,417)		49

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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
See PG6-Supp				Asbury Court LLC	Des Plaines	Ind & Asst Liv: SLF
				Asbury Healthcare	Skokie	Management Co.
				Asbury Gardens	North Aurora	Supportive Living
				SLF, LLC		Facility
				Des Plaines	Des Plaines	Real Estate
				Propoerty, LLC		

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	6	Maintenance	$		100%	$ 87	$ 87	1
2	V	19	Administrative			100%	34,505	34,505	2
3	V	21	Clerical	13		100%	1,113	1,100	3
4	V	26	Insurance			100%	4,114	4,114	4
5	V	30	Depreciation			100%	390,228	390,228	5
6	V	32	Interest	2,944		100%	385,337	382,393	6
7	V	33	Real Estate			100%	13,990	13,990	7
8	V	34	Rent	307,774		100%		(307,775)	8
9	V	36	Other			100%	15,109	15,109	9
10	V	43	Other			100%	336	336	10
11	V								11
12	V								12
13	V								13
14	Total			$ 310,731			$ 844,819	$ * 534,087	14

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

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Abraham Diamond	10%						1
2	Joseph Chase	10%						2
3	Moshe Kahn	10%						3
4	Shosana Kahn	10%						4
5	Yael Zahtz	10%						5
6	Samuel Sleeski	10%						6
7	Elisheva Chase	10%						7
8	Michael Zahtz	10%						8
9	Rachel Diamond	10%						9
10	Miriam Seleski	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
28								28
29								29
30								30

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LL # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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 [ ] NO [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2		N/A								2
3										3
4										4
5										5
6										6
7										7
8										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	TOTALS					$	$		$	25

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Capital One HUD Loan		X	Mortgage	221,219	4/1/2019	$ 28,449,200	$ 13,911,755	8/31/2053	0.0435	$ 223,392	1
2	MB Financial - Construction		X	Mortgage -Construction	Interest Only	9/1/2015	0	0	9/15/2018	Variable	141,873	2
3												3
4												4
5	Amortization Expense										20,341	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$221,219.00		$ 28,449,200	$ 13,911,755			$ 385,606	9
	B. Non-Facility Related*											
10												10
11												11
12								Loan Fees			(270)	12
13								Offset Interest Income			(2,944)	13
14	TOTAL Non-Facility Related						$	$			$ (3,214)	14
15	TOTALS (line 9+line14)						$ 28,449,200	$ 13,911,755			$ 382,392	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 15,109 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 Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**			1
	2017		
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.)		$ 13,990	2
3. Under or (over) accrual (line 2 minus line 1).		$ 13,990	3
4. Real Estate Tax accrual used for 2018 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
	Alloc Fr. Mgmt Co.		
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.		$ 13,990	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	N/A	8
	2014		9
	2015		10
	2016		11
	2017		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Asbury Court Nursing & Rehabilitation, LLC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055012

CONTACT PERSON REGARDING THIS REPORT Michael Zahtz

TELEPHONE (847) 228-1500 FAX #: (847) 228-1579

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-26-201-034-0000	Skilled Nursing Facility	$ 13,990.42	$ 13,990.42
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 13,990.42	$ 13,990.42

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,535 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories Two

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? [ ] (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).

Supportive Living Facility - 150 units, 179 beds
Assisted Living Facility - 162 units, 194 beds

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	Facility	56,390	1994	$ 1,062,315	1
2					2
3	TOTALS	56,390		$ 1,062,315	3

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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	71			2018	$ 7,120,730	$ -	40	89,009	$ 89,009	$ 89,009	4
5						-		-			5
6						-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
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
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											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 Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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							$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									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)		$ 7,120,730	$		$ 89,009	$ 89,009	$ 89,009	70

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

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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	$	$	$	$ -		$	71
72	Current Year Purchases	64,776		6,478	6,478	6,478	6,478	72
73	Fully Depreciated Assets				-			73
74					-			74
75	TOTALS	$ 64,776	$	$ 6,478	$ 6,478		$ 6,478	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					$	$	$ -		$	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)	$	8,247,821	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)	$	95,487	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	95,487	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	95,487	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		$	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 Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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. [X] 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:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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 [X] 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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 6,269 Description: Copy Machine $3,172, Ice Machine $3,094, Dietary $3.00
(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 & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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 Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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	39(3)	hrs	$	396	$ 28,480	$ 42	396	$ 28,522	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		131	9,467	14	131	9,481	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		499	35,929	52	499	35,981	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				35,448		35,448	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Ambulance	39(3)				488			488	12
13	Other (specify):									13
14	TOTAL			$	1,026	$ 74,364	$ 35,556	1,026	$ 109,920	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.

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 2/28/19 (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	$ 39,474	$ 48,926	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	364,598	364,994	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	30,714	31,409	7
8	Accounts Receivable (owners or related parties)	850	9,242	8
9	Other(specify): See Sch 17A		468,427	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 435,636	$ 922,998	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,062,315	13
14	Buildings, at Historical Cost		7,120,730	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	64,776	64,776	16
17	Accumulated Depreciation (book methods)		(95,487)	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)**	$ 64,776	$ 8,152,334	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 500,412	$ 9,075,332	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 139,838	$ 140,510	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,600	54,600	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 Sch 17A	442,679	477,101	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 637,117	$ 672,211	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		13,911,755	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)**	$	$ 13,911,755	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 637,117	$ 14,583,966	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (136,705)	$ (5,508,634)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 500,412	$ 9,075,332	48

***(See instructions.)**

Facility Name: **Asbury Court Nursing & Rehabilitation, LLC**
IDPH License ID Number: **0055012**
Fiscal Year End: **2/28/19**

Schedule 17A

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

	Description	Operating	After Consolidation
2500	Due to Ashley Management	-	46,155
2998.1	HUD Replacement Reserve	-	5,032
2998.2	HUD Initial Operating Deficit	-	89,330
2998.3	HUD Non-Critical Repair Escrow	-	1,789
2998.4	HUD MIP Escrow	-	15,095
2998.5	Real Estate Escrow	-	18,766
2998.6	Property Insurance Escrow	-	4,666
2998.7	Closing Costs	-	287,594
	Total - Line 9	**-**	**468,427**

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

	Description	Operating	After Consolidation
2051	Management Fee Payable	20,728	20,728
2060	Due to Asbury Court	381,877	382,074
2061	Due to Asbury Healthcare	39,925	39,925
2070	Due to BCHH	29	29
2550	Sales Tax Payable	120	120
2210-99	Accrued Expenses	-	34,225
	Total - Line 36	**442,679**	**477,101**

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3	**Prior Period Adjustments**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(851,921)	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) **Member 1 Equity**	715,216	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (136,705)	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)**	$ (136,705)	24 *

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

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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	$ 476,322	1
2	Discounts and Allowances for all Levels	(68,341)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 407,981	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	5,244	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,244	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Misc Income**	6	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 413,231	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	112,368	31
32	Health Care	274,945	32
33	General Administration	272,781	33
	B. Capital Expense		
34	Ownership	314,043	34
	C. Ancillary Expense		
35	Special Cost Centers	286,469	35
36	Provider Participation Fee	4,546	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,265,152	40
41	**Income before Income Taxes (line 30 minus line 40)****	(851,921)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (851,921)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue	23,795	45
46	Medicare - Net Inpatient Revenue	384,186	46
47	Other-(specify) **Managed care**		47
48	Other-(specify) **Hospice**		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 407,981	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.**

^ **Entity is a cash basis taxpayer**

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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	916	1,078	$ 53,509	$ 49.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,099	4,822	165,841	34.39	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	1,334	1,569	22,550	14.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	99	117	1,875	16.03	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	715	841	8,920	10.61	15
16	Dishwashers					16
17	Maintenance Workers	145	171	3,935	23.01	17
18	Housekeepers	980	1,153	12,921	11.21	18
19	Laundry					19
20	Administrator	683	803	52,408	65.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					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: MDS Coordinator	46	55	2,868	52.15	32
33	Other(specify) Marketing	532	626	22,891	36.57	33
34	TOTAL (lines 1 - 33)	9,549	11,235	$ 347,718 *	$ 30.95	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	$ 1,300	1(3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	147	10(3)	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	Monthly	2,176	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 3,623		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ N/A		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Kalas	Administrator	0	$ 52,408
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 52,408

B. Administrative - Other

Description	Amount
Management Fees (Adjusted on Schedule V Column 7)	$ 20,728
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 20,728

C. Professional Services

Vendor/Payee	Type	Amount
See SCH 21C		$ 46,401
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 46,401

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	(11,865)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ (11,865)

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	40,404
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 1	11
Miscellaneous Licenses & Fees	28,946
Miscellaneous Dues & Subscriptions	10,536
Allocated from RE Entity	
Direct Tv	2,982
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 84,869

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ N/A
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name: **Asbury Court Nursing & Rehabilitation, LLC**
IDPH License ID Number: **0055012**
Fiscal Year End: **2/28/19**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
ADP	Payroll Processing	539
Allscripts	Nursing Software	1,974
Zirmed	Accounting Software	163
Point Click Care	Monthly Software	4,923
RSM US LLP	Accounting	3,345
Achieve Accrediation	Nursing Consulting Services	950
Personnel Planners, Inc.	Unemployment Consulting	75
KBC	Consulting Services	1,406
RSM US LLP	Consulting Services	1,050
Polsinelli	Legal Services	4,231
Gutnicki	Legal Services	260
Asbury Healthcare	Consulting	16,884
Asbury Healthcare	Bookkeeping	10,601
	Total (agree to Schedule V, line 19, column 3)	46,401
Allocated from Management Company	Legal Fees	591
Allocated from Management Company	Professional Services	33,914
	Total (agree to Schedule V, line 19, column 8)	80,906

Facility Name & ID Number Asbury Court Nursing & Rehabilitation, LLC # 0055012 Report Period Beginning: 8/16/18 Ending: 2/28/19

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. $ **1,488** 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. $ **4,546**
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. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(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? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
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 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.