		FOR BHF USE					

LL1

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.

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

I. IDPH License ID Number: 0051193

Facility Name: Asbury Pavilion Nursing and Rehabilitation Center, LLC

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 1/1/18 to 12/31/18 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 Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	27,375	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	27,375	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	4,508	1,723	15,197	21,428	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,508	1,723	15,197	21,428	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.28%

D. How many bed reserve days during this year were paid by the Department?
N/A (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 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 6,286

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 & ID Number Asbury Pavilion Nursing and Rehabilitation (# 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	150,427	23,419	30,278	204,124		204,124	-	204,124			1
2	Food Purchase		105,111		105,111		105,111	-	105,111			2
3	Housekeeping	78,444	13,916	430	92,790		92,790	-	92,790			3
4	Laundry	4,918	-	-	4,918		4,918	-	4,918			4
5	Heat and Other Utilities			69,968	69,968		69,968	-	69,968			5
6	Maintenance	34,847	12,801	54,392	102,040		102,040	-	102,040			6
7	Other (specify):*	-	-	-				-				7
8	**TOTAL General Services**	268,636	155,247	155,068	578,951		578,951		578,951			8
	B. Health Care and Programs											
9	Medical Director	-	-	7,454	7,454		7,454	-	7,454			9
10	Nursing and Medical Records	1,746,622	131,589	123,973	2,002,184		2,002,184	15,102	2,017,286			10
10a	Therapy	-	-	-				-				10a
11	Activities	-	-	-				-				11
12	Social Services	106,972	1,671	13,793	122,436		122,436	-	122,436			12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	-				-				14
15	Other (specify):*	-	-	-				-				15
16	**TOTAL Health Care and Programs**	1,853,594	133,260	145,220	2,132,074		2,132,074	15,102	2,147,176			16
	C. General Administration											
17	Administrative	130,772	-	360,113	490,885		490,885	(360,113)	130,772			17
18	Directors Fees			-				-				18
19	Professional Services			243,040	243,040		243,040	(14,077)	228,963			19
20	Dues, Fees, Subscriptions & Promotions			63,008	63,008		63,008	334	63,342			20
21	Clerical & General Office Expenses	55,794	20,503	13,836	90,133		90,133	(104,814)	(14,681)			21
22	Employee Benefits & Payroll Taxes			250,720	250,720		250,720	-	250,720			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			2,435	2,435		2,435	-	2,435			24
25	Other Admin. Staff Transportation		-	288	288		288	6,187	6,475			25
26	Insurance-Prop.Liab.Malpractice			169,532	169,532		169,532	4,249	173,781			26
27	Other (specify):* Mgmt. Co. Benefits	-	-	-				935	935			27
28	**TOTAL General Administration**	186,566	20,503	1,102,972	1,310,041		1,310,041	(467,299)	842,742			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,308,796	309,010	1,403,260	4,021,066		4,021,066	(452,197)	3,568,869			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 Pavilion Nursing and Rehabilitation Center, LLC #0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			-				238,913	238,913			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			-				138,982	138,982			32
33	Real Estate Taxes			-				46,999	46,999			33
34	Rent-Facility & Grounds			317,256	317,256		317,256	(311,097)	6,159			34
35	Rent-Equipment & Vehicles			32,084	32,084		32,084	-	32,084			35
36	Other (specify):* HUD MIP Expense			-				24,057	24,057			36
37	**TOTAL Ownership**			349,340	349,340		349,340	137,854	487,194			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	207,236	1,107,087	1,314,323		1,314,323	-	1,314,323			39
40	Barber and Beauty Shops	-	-	-				-				40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			118,504	118,504		118,504	-	118,504			42
43	Other (specify):* Non-Allowable Cos	107,491	-	359,771	467,262		467,262	(467,262)				43
44	**TOTAL Special Cost Centers**	107,491	207,236	1,585,362	1,900,089		1,900,089	(467,262)	1,432,827			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,416,287	516,246	3,337,962	6,270,495		6,270,495	(781,605)	5,488,890			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 Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	114,936	30		9
10	Interest and Other Investment Income	(4,033)	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	(2,917)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(254,569)	43		24
25	Fund Raising, Advertising and Promotional	(60,360)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(112)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(248,670)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (455,725)		$	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)	(325,880)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (325,880)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (781,605)		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 Pavilion Nursing and Rehabilitation Center, LLC

ID# 0051193

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salaries	$ (107,491)	43	1
2	Labs - Part A	(24,258)	43	2
3	X-Rays - Part A	(5,135)	43	3
4	Wound Care	(2,070)	43	4
5	Consolidated Billing	(13,379)	43	5
6	Offset Misc. Income	(1,329)	21	6
7	Adjust RE taxes	14,301	33	7
8	Nonallowable marketing events	(53)	43	8
9	Offset Related Party Expense	(109,256)	34	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**	(248,670)		49

Facility Name & ID Number Asbury Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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%	$ 2,183	$ 2,183	1
2	V	20	Dues and Subscriptions		EJR Enterprises, Inc.	60%	113	113	2
3	V	26	Property Insurance Exp		EJR Enterprises, Inc.	60%	2,470	2,470	3
4	V	32	Amortization Expense		EJR Enterprises, Inc.	60%	15,849	15,849	4
5	V	30	Depreciation Expense		EJR Enterprises, Inc.	60%	123,978	123,978	5
6	V	32	Interest: Capital One Loan		EJR Enterprises, Inc.	60%	127,980	127,980	6
7	V	32	Interest: SNF Loan Int Exp	814	EJR Enterprises, Inc.	60%		(814)	7
8	V	36	HUD MIP Expense		EJR Enterprises, Inc.	60%	24,057	24,057	8
9	V	33	Taxes - Property		EJR Enterprises, Inc.	60%	32,698	32,698	9
10	V	34	Rent	208,000	EJR Enterprises, Inc.	60%		(208,000)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 208,814			$ 329,328	$ * 120,514	14

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

Facility Name & ID Number Asbury Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 188,205	Asbury Gardens SLF, LLC	60%	$ 188,205	$	15
16	V	2	Food	104,982	Asbury Gardens SLF, LLC	60%	104,982		16
17	V	3	Housekeeping	8,541	Asbury Gardens SLF, LLC	60%	8,541		17
18	V	5	Utilities	69,969	Asbury Gardens SLF, LLC	60%	69,969		18
19	V	6	Repairs & Maintenance	52,760	Asbury Gardens SLF, LLC	60%	52,760		19
20	V	12	Social Services	983	Asbury Gardens SLF, LLC	60%	983		20
21	V	17	Administrator	11,330	Asbury Gardens SLF, LLC	60%	11,330		21
22	V	20	Dues and Subscriptions	361	Asbury Gardens SLF, LLC	60%	361		22
23	V	21	Office Expense	10,297	Asbury Gardens SLF, LLC	60%	10,297		23
24	V	43	Advertising	(51,506)	Asbury Gardens SLF, LLC	60%	(51,506)		24
25	V								25
26	V								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			$ 395,922			$ 395,922	$ *	39

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

Facility Name & ID Number Asbury Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 360,113	Asbury Healthcare	60%	$	$ (360,113)	15
16	V	19	Professional Fees		Asbury Healthcare	60%	1,759	1,759	16
17	V	20	Licenses & Permits		Asbury Healthcare	60%	37	37	17
18	V	20	Personnel Recruitment		Asbury Healthcare	60%	184	184	18
19	V	21	Administrative Salaries	184,224	Asbury Healthcare	60%	77,793	(106,431)	19
20	V	21	Office Supplies		Asbury Healthcare	60%	2,945	2,945	20
21	V	25	Auto Expense		Asbury Healthcare	60%	6,187	6,187	21
22	V	26	Insurance		Asbury Healthcare	60%	1,779	1,779	22
23	V	27	Mgmt. Alloc. - EE Benefits (Health)		Asbury Healthcare	60%	660	660	23
24	V	27	Mgmt. Alloc. - EE Benefits (W/C)		Asbury Healthcare	60%	275	275	24
25	V	34	Rent Expense		Asbury Healthcare	60%	6,159	6,159	25
26	V	43	State Taxes		Asbury Healthcare	60%	112	112	26
27	V	43	Events		Asbury Healthcare	60%	53	53	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			$ 544,337			$ 97,943	$ * (446,394)	39

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

Facility Name & ID Number Asbury Pavilion Nursing and Rehabilitation # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 187,771	$ 129,894	1	$ 187,771	1
2	1	Dietary Equip Rental & R&M	Total Beds / Units	298	2	1,725		75	434	2
3	2	Food	Direct	1	1	104,983		1	104,983	3
4	3	Housekeeping Supplies	Total Beds / Units	298	2	33,936		75	8,541	4
5	5	Utilities	Total Beds / Units	298	2	278,009		75	69,969	5
6	6	Maintenance Salaries & Taxes	Direct	1	1	29,332	26,665	1	29,332	6
7	6	Maintenance Supplies & Others	Total Beds / Units	298	2	93,088		75	23,428	7
8	12	Activities & Social Services	Direct	1	1	983		1	983	8
9	17	Admin Salaries & Taxes	Direct	1	1	11,330	10,300	1	11,330	9
10	20	Permits, Dues and Subscriptions	Total Beds / Units	298	2	1,436		75	361	10
11	21	Campus Office Expense	Direct	1	1	11,756		1	11,756	11
12	21	Admin Office Expense	Total Beds / Units	298	2	25,423		75	6,398	12
13	43	Marketing Salaries & Taxes	Direct	1	1	(64,945)	(59,041)	1	(64,945)	13
14	43	Advertising	Total Beds / Units	298	2	22,180		75	5,582	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 737,007	$ 107,818		$ 395,922	25

Facility Name & ID Number Asbury Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	244,915	3	$ 15,737	$	27,375	$ 1,759	1
2	20	Licenses & Permits	Bed Days Available	244,915	3	330		27,375	37	2
3	20	Personnel Recruitment	Bed Days Available	244,915	3	1,646		27,375	184	3
4	21	Administrative Salaries	Bed Days Available	244,915	3	695,994		27,375	77,794	4
5	21	Office Supplies	Bed Days Available	244,915	3	26,350		27,375	2,945	5
6	25	Auto Expense	Bed Days Available	244,915	3	55,355		27,375	6,187	6
7	26	Insurance	Bed Days Available	244,915	3	15,916		27,375	1,779	7
8	27	Mgmt. Alloc. - EE Benefits (Health	Bed Days Available	244,915	3	5,901		27,375	660	8
9	27	Mgmt. Alloc. - EE Benefits (W/C)	Bed Days Available	244,915	3	2,462		27,375	275	9
10	34	Rent Expense	Bed Days Available	244,915	3	55,100		27,375	6,159	10
11	43	State Taxes	Bed Days Available	244,915	3	1,000		27,375	112	11
12	43	Events	Bed Days Available	244,915	3	473		27,375	53	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					$ 876,264	$		$ 97,943	25

Facility Name & ID Number Asbury Pavilion Nursing and Rehabilitation C # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	Capital One HUD Loan		X	Construction / Mortgage	23,119.75	06/01/16	$ 3,863,128	$ 3,718,909	07/01/51	0.0342	$ 127,980	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$23,119.75		$ 3,863,128	$ 3,718,909			$ 127,980	9
	B. Non-Facility Related*											
10								Allocated from RE Entity - Amortization			15,849	10
11												11
12								Interest Income Offset			(4,847)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 11,002	14
15	TOTALS (line 9+line14)						$ 3,863,128	$ 3,718,909			$ 138,982	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 24,057 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 Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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
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.)	2017	$ 46,999	2
3. Under or (over) accrual (line 2 minus line 1).		$ 46,999	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
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.)**	Alloc Fr. Mgmt Co.	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 46,999	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	8,940	8
	2014	17,387	9
	2015	48,712	10
	2016	49,298	11
	2017	46,999	12

Facility does not accrue real estate taxes.

	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 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 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.	15-04-451-010	Skilled Nursing Facility	$ 46,998.94	$ 46,998.94
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,998.94	$ 46,998.94

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 Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 535,500	4
5						-		-			5
6						-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
9	Utility Building - Hot Water, Data, Telephone & Electrical		2010	2010	168,592	-	40	4,215	4,215	35,825	9
10						-		-			10
11	Excavate & Install new Sidewalk - West Side of Building		2014	2014	3,800	-	15	253	253	1,140	11
12						-		-			12
13	Patch, prime & paint walls around AC units outside; replace		2015	2015	2,750	-	15	183	183	642	13
14	Relocate main water line and sprinkler in nursing home		2015	2015	6,900	-	15	460	460	1,610	14
15						-		-			15
16	Installation of digital television capabilities throughout facili		2015	2015	15,381	-	15	1,025	1,025	3,589	16
17	Install shelves to the walls and wiring					-		-			17
18						-		-			18
19	R/M Reclass - Plumbing: HydroJett Sewer Service; Root Inti		2015	2015	12,080	-	15	805	805	2,819	19
20						-		-			20
21	R/M Reclass - Install indoor/outdoor keypad locks & prograi		2015	2015	3,898	-	15	260	260	910	21
22	with alarm system - Nursing & Rehabilitation wing - 212 B					-		-			22
23						-		-			23
24	R/M Reclass - Circuit room Battery Replacement - 2 8D Batt		2015	2015	2,784	-	5	557	557	1,949	24
25						-		-			25
26	R/M Reclass - Mechanical repairs to rooftop units; modified		2015	2015	17,673	-	15	1,178	1,178	4,124	26
27						-		-			27
28	R/M Reclass - Repair to RTU electrical room, replaced igniti		2015	2015	3,055	-	15	204	204	713	28
29	Washed coils, repaired disconnected heat and power					-		-			29
30						-		-			30
31	Dining Room - Install back wall, install paneling and corner		2015	2015	6,420	-	15	428	428	1,498	31
32	Relocate electrical and water line for new equipment					-		-			32
33						-		-			33
34	Electrical Room - Installed one Energy meter for the ATS, in		2015	2015	2,560	-	15	171	171	597	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 Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 1,847	$ 1,847	$ 4,616	37
38				-		-			38
39	R/M Reclass: Plumbing and Sewer Repair in Rooms 301, 302 and	2016	3,310	-	20	166	166	414	39
40				-		-			40
41	R/M Reclass: Tempering Valve above Heater Replacement in	2016	3,528	-	10	353	353	882	41
42	Mechanical Room			-		-			42
43				-		-			43
44	R/M Reclass: Laundry Room Upgrades - Permit, Architectural	2016	25,155	-	20	1,258	1,258	3,145	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	$		$ 132,362	$ 132,362	$ 599,971	70

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

Facility Name & ID Number Asbury Pavilion Nursing and Rehabilitation Center, # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 532,762	$	$ 106,551	$ 106,551	5	$ 453,601	71
72	Current Year Purchases				-			72
73	Fully Depreciated Assets				-			73
74					-			74
75	TOTALS	$ 532,762	$	$ 106,551	$ 106,551		$ 453,601	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)	$ 5,778,584	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)	$ 238,913	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 238,913	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,053,572	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 Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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				6,159			6
7	TOTAL				$ 6,159 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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

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

16. Rental Amount for movable equipment: $ 32,084 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 Pavilion Nursing and Rehabilitation Center, LLC**
IDPH License ID Number: **0051193**
Fiscal Year End: **12/31/18**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	(1,529)
Knife	87
Nursing Equipment	25,791
Therapy Equipment	7,735
Total - Line 16	**32,084**

Facility Name & ID Number Asbury Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	6,356	$ 457,659	$ 110	6,356	$ 457,769	1
2	Licensed Speech and Language Development Therapist	L39(2)(3)	hrs		1,536	110,568	27	1,536	110,595	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39(2)(3)	hrs		7,436	535,403	129	7,436	535,532	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				198,069		198,069	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39(2)					8,901		8,901	12
13	Other (specify): Ambulance	L39(3)				3,457			3,457	13
14	TOTAL			$	15,328	$ 1,107,087	$ 207,236	15,328	$ 1,314,323	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 Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	$ 555,823	$ 555,823	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	1,687,791	1,687,791	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	122,504	122,504	7
8	Accounts Receivable (owners or related parties)	358	358	8
9	Other(specify): See Schedule 17A	248,699	248,699	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,615,175	$ 2,615,175	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		532,762	16
17	Accumulated Depreciation (book methods)		(1,053,572)	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 (spc			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 4,725,012	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,615,175	$ 7,340,187	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 178,543	$ 178,543	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,318	107,318	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	3,280,746	3,280,746	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,566,607	$ 3,566,607	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,718,909	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)**	$	$ 3,718,909	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,566,607	$ 7,285,516	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (951,432)	$ 54,671	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,615,175	$ 7,340,187	48

***(See instructions.)**

Facility Name: **Asbury Pavilion Nursing and Rehabilitation Center, LLC**
IDPH License ID Number: **0051193**
Fiscal Year End: **12/31/18**

Schedule 17A

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

Description	Operating	After Consolidation
Medicaid Holding Account	(1,957)	(1,957)
Exchange Clearing Account	31,732	31,732
Medicare Adjustment	7,706	7,706
Medicare Settlement	208,053	208,053
Medicaid Settlement	3,165	3,165
Total - Line 9	**248,699**	**248,699**

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
Total - Line 23	**-**	**-**

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

Description	Operating	After Consolidation
Due to Asbury Gardens	(1,557,738)	(1,557,738)
Management Fee Payable	(658,947)	(658,947)
Rent Payable	(1,002,000)	(1,002,000)
Due to Asbury Court	(19,950)	(19,950)
Due to Asbury Healthcare	(48,785)	(48,785)
Due to BCHH	(116)	(116)
Refunds Due/Clearing Account	9,893	9,893
Payroll Liabilities	(2,774)	(2,774)
Supplemental Insurance W/H	(172)	(172)
Due to Emp - Uncashed checks	(157)	(157)
Total - Line 36	**(3,280,746)**	**(3,280,746)**

Facility Name & ID Number Asbury Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,813,072)	1
2	Restatements (describe):		2
3	**Distributions**	(70,125)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,883,197)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	931,764	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**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 931,765	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)**	$ (951,432)	24 *

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

Facility Name & ID Number Asbury Pavilion Nursing and Rehabilitation Center # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 6,747,131	1
2	Discounts and Allowances for all Levels	(105,023)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,642,108	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	554,809	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 554,809	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(20)	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (20)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,033	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,033	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	1,329	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,329	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,202,259	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	578,951	31
32	Health Care	2,132,074	32
33	General Administration	1,310,041	33
	B. Capital Expense		
34	Ownership	349,340	34
	C. Ancillary Expense		
35	Special Cost Centers	1,781,585	35
36	Provider Participation Fee	118,504	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,270,495	40
41	**Income before Income Taxes (line 30 minus line 40)****	931,764	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 931,764	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,267,081	44
45	Private Pay - Net Inpatient Revenue	634,459	45
46	Medicare - Net Inpatient Revenue	3,367,397	46
47	Other-(specify) Managed Care	369,304	47
48	Other-(specify) Medicaid Pending	3,867	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,642,108	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 Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	2,004	2,358	$ 102,527	$ 43.48	1
2	Assistant Director of Nursing	1,536	1,807	66,991	37.08	2
3	Registered Nurses	9,740	11,459	402,622	35.14	3
4	Licensed Practical Nurses	8,233	9,686	277,256	28.62	4
5	CNAs & Orderlies	41,996	49,407	808,117	16.36	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	4,263	5,015	106,972	21.33	11
12	Dietician					12
13	Food Service Supervisor	215	253	8,393	33.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,826	11,561	142,034	12.29	15
16	Dishwashers					16
17	Maintenance Workers	1,060	1,247	34,847	27.95	17
18	Housekeepers	5,716	6,725	78,444	11.67	18
19	Laundry	418	491	4,918	10.01	19
20	Administrator	1,768	2,080	130,772	62.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,209	2,599	55,794	21.47	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: Nursing : MDS Sa	1,821	2,143	89,109	41.59	32
33	Other(specify) Marketing	1,175	1,382	107,491	77.79	33
34	TOTAL (lines 1 - 33)	91,978	108,210	$ 2,416,287 *	$ 22.33	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	$ 28,858	1(3)	35
36	Medical Director	Monthly	7,454	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	52,680	10(3)	38
39	Pharmacist Consultant	Monthly	18,591	10(3)	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	6,488	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 114,071		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	147	$ 7,648	10(3)	50
51	Licensed Practical Nurses	131	5,489	10(3)	51
52	Certified Nurse Assistants/Aides	1,325	29,158	10(3)	52
53	TOTAL (lines 50 - 52)	1,603	$ 42,295		53

Facility Name & ID Number Asbury Pavilion Nursing and Rehabilitation Center, I # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Elizabeth Gilbert	Administrator	0	$ 130,772
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 130,772

B. Administrative - Other

Description	Amount
Management Fees - Asbury Healthcare	$ 360,113
Eliminated in Col. 7	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 360,113

C. Professional Services

Vendor/Payee	Type	Amount
Achieve Accreditation	Accreditation	$ 17,610
ADP	Payroll Processing	8,417
Allscripts Healthcare, LLC	Software Consulting	3,075
Ashley Healthcare	Bookkeeping	117,029
Ben Lazare Consulting	State Reimbursement	1,250
Chubb Group	Legal	2,342
CIBC	Legal	582
Gutnicki LLP	Legal	701
Intuit	Accounting Software	260
James White	Dietary, Customer Relation Svcs	3,188
Jim White	Dietary, Customer Relation Svcs	11,100
See Schedule 21C		77,486
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 243,040

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,298
Unemployment Compensation Insurance	
FICA Taxes	195,272
Employee Health Insurance	18,150
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 250,720

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	40,524
Health Care Worker Background Check	
(Indicate # of checks performed 197)	2,365
Patient Background Checks 102	1,225
Miscellaneous Licenses & Fees	229
Miscellaneous Dues/Subscriptions	18,665
Allocated from Home Office	334
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 63,342

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,435
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,435

**See instructions.

Facility Name: **Asbury Pavilion Nursing and Rehabilitation Center, LLC**
IDPH License ID Number: **0051193**
Fiscal Year End: **12/31/18**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
KBC Computer Services	IT Support	428
Lyndsay Czwornog	Advertising / Branding	3,618
Markoff Law LLC	Legal	1,150
ML Group Design & Development LLC	Real Estate Development	25,002
MTS Consulting LLC	Tax Consulting	1,713
Nancy Hartmann	Software Consulting	528
PCC	Census,Nursing,Billing Software	113
Personnel Planners, Inc.	U/C Consulting	285
Pointb Communications Website	Website Design	164
Pointclickcare	Clinical Software	15,333
Polsinelli PC	Legal	13,808
RSM US LLP	Accounting	10,900
Ultra HC Consulting	Business Development	2,032
Wencel Worldwide	Website Design	1,000
Zirmed	Healthcare Mgmt Software	1,412
	From Page 21	165,554
	Total (agree to Schedule V, line 19, column 3)	243,040

Allocated from Management Company Professional Services	3,942
Less: Non-Allowable Legal Fees	(2,917)
Reclass Amount to Nursing Equipment	(15,102)
Total (agree to Schedule V, line 19, column 8)	228,963

Facility Name & ID Number Asbury Pavilion Nursing and Rehabilitation Center, LLC # 0051193 Report Period Beginning: 1/1/18 Ending: 12/31/18

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. $ **29,387** 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. $ **118,504**
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 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.