

Facility Name & ID Number Abbington Rehab And Nursing

0039693 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	22	Skilled (SNF)	22	8,030	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,900	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	29,930	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	4,081	810	1,657	6,548	8	
9	SNF/PED					9	
10	ICF	17,148	2,230		19,378	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	21,229	3,040	1,657	25,926	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.62%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 07/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/1994 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 19 and days of care provided 1,657

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	170,131	27,254	6,936	204,321		204,321	6,164	210,485		1
2	Food Purchase		121,244		121,244	(7,939)	113,305	(141)	113,164		2
3	Housekeeping	122,546	27,769		150,315		150,315		150,315		3
4	Laundry	27,312	7,720	42,978	78,010		78,010		78,010		4
5	Heat and Other Utilities			78,294	78,294		78,294	(2,739)	75,555		5
6	Maintenance	50,505	3,223	40,972	94,700		94,700	(1,524)	93,176		6
7	Other (specify):*							1,075	1,075		7
8	TOTAL General Services	370,494	187,210	169,180	726,884	(7,939)	718,945	2,835	721,780		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,212,870	78,627	5,755	1,297,252		1,297,252		1,297,252		10
10a	Therapy	35,059		540	35,599		35,599		35,599		10a
11	Activities	57,015	399	1,080	58,494		58,494		58,494		11
12	Social Services	35,517		2,082	37,599		37,599		37,599		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,340,461	79,026	15,457	1,434,944		1,434,944		1,434,944		16
	C. General Administration										
17	Administrative	93,168		296,675	389,843		389,843	(225,012)	164,831		17
18	Directors Fees										18
19	Professional Services			62,697	62,697	(10)	62,687	2,874	65,561		19
20	Dues, Fees, Subscriptions & Promotions			22,328	22,328		22,328	(10,199)	12,129		20
21	Clerical & General Office Expenses	67,075	7,748	66,106	140,929		140,929	333	141,262		21
22	Employee Benefits & Payroll Taxes			298,038	298,038	7,939	305,977		305,977		22
23	Inservice Training & Education										23
24	Travel and Seminar			734	734		734	109	843		24
25	Other Admin. Staff Transportation			1,029	1,029		1,029	2,557	3,586		25
26	Insurance-Prop.Liab.Malpractice			65,773	65,773		65,773	1,453	67,226		26
27	Other (specify):*							32,769	32,769		27
28	TOTAL General Administration	160,243	7,748	813,380	981,371	7,929	989,300	(195,116)	794,183		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,871,198	273,984	998,017	3,143,199	(10)	3,143,189	(192,282)	2,950,907		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

Abbington Rehab And Nursing

#0039693

Report Period Beginning:

01/01/15

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			22,027	22,027		22,027	102,993	125,020			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							5,362	5,362			32
33	Real Estate Taxes			33,058	33,058	10	33,068	2,914	35,982			33
34	Rent-Facility & Grounds			588,000	588,000		588,000	(588,000)				34
35	Rent-Equipment & Vehicles							4,202	4,202			35
36	Other (specify):*											36
37	TOTAL Ownership			643,085	643,085	10	643,095	(472,528)	170,567			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		49,280	218,430	267,710		267,710		267,710			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			192,116	192,116		192,116		192,116			42
43	Other (specify):*			10,500	10,500		10,500	(10,500)				43
44	TOTAL Special Cost Centers		49,280	421,046	470,326		470,326	(10,500)	459,826			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,871,198	323,264	2,062,148	4,256,610		4,256,610	(675,310)	3,581,300			45

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

Abbington Rehab And Nursing

ID# 0039693

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Sequestration	\$ (18,277)	21	1
2	Building Co. - Accounting Fees	(1,250)	19	2
3	Building Co. - LLC Fees	(250)	20	3
4	Buildng Co. - Illinois Replacement Tax	(4,908)	21	4
5	Marketing	(10,500)	43	5
6	Collection Expense	(1,245)	21	6
7	PAC Dues	(2,914)	20	7
8	Capitalized R&M	(5,600)	06	8
9	Non-Allowable Legal	(1,736)	19	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	(46,680)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Abbington Rehab And Nursing# 0039693

Report Period Beginning:

01/01/15

Ending:

12/31/15

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				6,164								6,164	1
2	Food Purchase	(141)											(141)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,725)		986									(2,739)	5
6	Maintenance	(5,600)		1,005	3,071								(1,524)	6
7	Other (specify):*				1,075								1,075	7
8	TOTAL General Services	(9,466)		1,991	10,310								2,835	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(278,990)	53,978								(225,012)	17
18	Directors Fees													18
19	Professional Services	(2,986)	1,250	4,430		180							2,874	19
20	Fees, Subscriptions & Promotions	(10,475)	250	26									(10,199)	20
21	Clerical & General Office Expenses	(46,487)	4,908	41,912									333	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			109									109	24
25	Other Admin. Staff Transportation			2,557									2,557	25
26	Insurance-Prop.Liab.Malpractice			1,182		271							1,453	26
27	Other (specify):*			29,081	3,688								32,769	27
28	TOTAL General Administration	(59,948)	6,408	(199,693)	57,666	451							(195,116)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(69,415)	6,408	(197,702)	67,976	451							(192,282)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending:

12/31/15

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	41,479	59,827	268		1,419							102,993	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,045)	6,285			1,122							5,362	32
33	Real Estate Taxes					2,914							2,914	33
34	Rent-Facility & Grounds		(588,000)	8,548		(8,548)							(588,000)	34
35	Rent-Equipment & Vehicles			4,202									4,202	35
36	Other (specify):*													36
37	TOTAL Ownership	39,434	(521,888)	13,018		(3,092)							(472,528)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(10,500)											(10,500)	43
44	TOTAL Special Cost Centers	(10,500)											(10,500)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(40,481)	(515,480)	(184,684)	67,976	(2,642)							(675,310)	45

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 588,000	Abbington Health Care Associates, LLC		\$	\$ (588,000)	1
2	V	32 Interest Income	8	Abbington Health Care Associates, LLC			(8)	2
3	V	32 Mortgage Interest		Abbington Health Care Associates, LLC		6,293	6,293	3
4	V	30 Depreciation		Abbington Health Care Associates, LLC		59,827	59,827	4
5	V	19 Accounting Fees		Abbington Health Care Associates, LLC		1,250	1,250	5
6	V	20 LLC Fees		Abbington Health Care Associates, LLC		250	250	6
7	V	21 Illinois Replacement Tax		Abbington Health Care Associates, LLC		4,908	4,908	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 588,008			\$ 72,528	\$ * (515,480)	14

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

Facility Name & ID Number Abbington Rehab And Nursing

0039693

Report Period Beginning: 01/01/15

Ending: 12/31/15

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	STAYCARE MANAGEMENT, LTD.	100.00%	\$ 986	\$	986	15
16	V	6 REPAIRS AND MAINT.				1,005		1,005	16
17	V	17 ADMIN. SALARY				17,685		17,685	17
18	V	19 PROFESSIONAL FEES				4,430		4,430	18
19	V	20 DUES, SUBSCRIPTIONS				26		26	19
20	V	21 CLERICAL & GENERAL				41,912		41,912	20
21	V	24 SEMINARS				109		109	21
22	V	25 ADMIN. STAFF TRAVEL				2,557		2,557	22
23	V	26 INSURANCE				1,182		1,182	23
24	V	27 EMPLOYEE BENEFITS				29,081		29,081	24
25	V	30 DEPRECIATION				268		268	25
26	V	32 INTEREST EXPENSE							26
27	V	34 BUILDING RENT				8,548		8,548	27
28	V	35 EQUIPMENT RENTAL				4,202		4,202	28
29	V								29
30	V	17 Management Fees	296,675					(296,675)	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		\$ 296,675			\$ 111,991	\$ *	(184,684)	39

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$ 1,553	\$	1,553	15
16	V	1 DIET. COMP - D. WENGROW				4,611		4,611	16
17	V	6 MAINT. COMP.				3,071		3,071	17
18	V	7 EMP. BEN. - S. WEBSTER				212		212	18
19	V	7 EMP. BEN. - D. WENGROW				477		477	19
20	V	7 EMP. BEN. - MAINT. NON-OWNER				386		386	20
21	V	17 ADMIN. COMP - H. WENGROW				40,074		40,074	21
22	V	17 ADMIN. COMP - J. WEBSTER				13,904		13,904	22
23	V	27 EMP. BEN. - H. WENGROW				2,796		2,796	23
24	V	27 EMP. BEN. - J. WEBSTER				892		892	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		\$			\$ 67,976	\$ *	67,976	39

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$		100.00%	\$		15
16	V	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		180	180	16
17	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		271	271	17
18	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		1,419	1,419	18
19	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		1,122	1,122	19
20	V	19 RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC				20
21	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		2,914	2,914	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	8,548	DOUBLE YOU REALTY, LLC			(8,548)	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		\$ 8,548			\$ 5,906	\$ * (2,642)	39

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							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		\$			\$	\$ *	39

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							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		\$			\$	\$ *	39

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							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		\$			\$	\$ *	39

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							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		\$			\$	\$ *	39

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							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		\$			\$	\$ *	39

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							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		\$			\$	\$ *	39

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

Facility Name & ID Number

Abbington Rehab And Nursing

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0039693

Report Period Beginning:

01/01/15

Ending:

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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	Jeffrey Webster	Owner	Administrative	50.00%	See Attached	5.00	7.14%	Alloc. Salary	\$ 13,904	17-07	1	
2	Howard Wengrow	Owner	Administrative	50.00%	See Attached	15.00	23.08%	Alloc. Salary	40,074	17-07	2	
3	Sara Webster	Relative	Dietary		See Attached	0.77	15.37%	Alloc. Salary	1,553	01-07	3	
4	Deborah Wengrow	Relative	Dietary		See Attached	0.77	15.37%	Alloc. Salary	4,611	01-07	4	
5	Ephraim Braunstein	Relative	Clerical		See Attached	4.63	11.58%	Alloc. Salary	7,502	21-07	5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 67,644		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 Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

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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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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 Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

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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

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

Name of Related Organization STAYCARE MANAGEMENT, LTD.
 Street Address 3737 W ARTHUR AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 679-2121
 Fax Number (847) 679-2122

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	223,823	6	\$ 8,516	\$ 25,926	\$ 986	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	223,823	6	8,680	25,926	1,005	2
3	17	ADMIN. SALARY	PATIENT DAYS	223,823	6	152,674	152,674	25,926	17,685
4	19	PROFESSIONAL FEES	PATIENT DAYS	223,823	6	38,246	25,926	4,430	4
5	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	223,823	6	222	25,926	26	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	223,823	6	361,830	307,546	25,926	41,912
7	24	SEMINARS	PATIENT DAYS	223,823	6	945	25,926	109	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	223,823	6	22,074	25,926	2,557	8
9	26	INSURANCE	PATIENT DAYS	223,823	6	10,203	25,926	1,182	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	223,823	6	251,057	25,926	29,081	10
11	30	DEPRECIATION	PATIENT DAYS	223,823	6	2,315	25,926	268	11
12	32	INTEREST	PATIENT DAYS	223,823	6		25,926		12
13	34	BUILDING RENT	PATIENT DAYS	223,823	6	73,800	25,926	8,548	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	223,823	6	36,278	25,926	4,202	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 966,840	\$ 460,220	\$ 111,991	25

Facility Name & ID Number Abbington Rehab And Nursing

0039693

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01/01/15

Ending: 12/31/15

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

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

Name of Related Organization STAYCARE MANAGEMENT, LTD.
 Street Address 3737 W ARTHUR AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 679-2121
 Fax Number (847) 679-2122

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104	1	1,553	1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	30,000	30,000	1	4,611	2
3	6	MAINT. COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	5	3,071	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	1,381		1	212	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	3,107		1	477	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	3,328		5	386	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	173,652	173,652	15	40,074	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	194,652	194,652	5	13,904	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,114		15	2,796	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,481		5	892	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					\$ 467,329	\$ 434,918		\$ 67,976	25

Facility Name & ID Number Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization DOUBLE YOU REALTY, LLC
 Street Address 3737 W. ARTHUR AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 679-2121
 Fax Number (847) 679-2122

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	223,823	6	1,550	25,926	180	2
3	26	INSURANCE	PATIENT DAYS	223,823	6	2,342	25,926	271	3
4	30	DEPRECIATION	PATIENT DAYS	223,823	6	12,254	25,926	1,419	4
5	32	INTEREST EXPENSE	PATIENT DAYS	223,823	6	9,684	25,926	1,122	5
6	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	223,823	6		25,926		6
7	33	REAL ESTATE TAXES	PATIENT DAYS	223,823	6	25,161	25,926	2,914	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				\$	50,991	\$	5,906	25

Facility Name & ID Number Abbington Rehab And Nursing

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01/01/15

Ending: 12/31/15

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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 Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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 Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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 Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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 Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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 Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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

Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		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	MB Financial		X	Mortgage			\$	\$		\$ 6,293	1							
2											2							
3	Allocated from Double You Realty		X	Mortgage						1,122	3							
4											4							
5											5							
Working Capital																		
6											6							
7											7							
8											8							
9	TOTAL Facility Related						\$	\$		\$ 7,415	9							
B. Non-Facility Related*																		
10	Interest Income		X							(2,045)	10							
11	Interest Income - Bldg Co.		X							(8)	11							
12											12							
13											13							
14	TOTAL Non-Facility Related						\$	\$		\$ (2,053)	14							
15	TOTALS (line 9+line14)						\$	\$		\$ 5,362	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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

Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1	2	3	4	5	6		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						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	TOTAL Long-Term										7							
Working Capital																		
8						\$	\$			\$	8							
9											9							
10											10							
11											11							
12											12							
13											13							
14	TOTAL Working Capital										14							
B. Non-Facility Related*																		
15						\$	\$			\$	15							
16											16							
17											17							
18											18							
19											19							
20	TOTAL Non-Facility Related										20							

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2014 report.		\$	33,267	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.)		\$	35,587	2											
3. Under or (over) accrual (line 2 minus line 1).		\$	2,320	3											
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	33,653	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.)		\$	10	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 \$ <u>34</u> For 2004, <u>2008</u> 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.		\$	35,983	7											
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	<u>28,067</u>	<u>8</u>	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$ 13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ 14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ 15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ 16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13	14	PLUS APPEAL COST FROM LINE 5 \$ 14	15	LESS REFUND FROM LINE 6 \$ 15	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13														
14	PLUS APPEAL COST FROM LINE 5 \$ 14														
15	LESS REFUND FROM LINE 6 \$ 15														
16	AMOUNT TO USE FOR RATE CALCULATION \$ 16														
	2011	<u>26,671</u>	<u>9</u>												
	2012	<u>31,395</u>	<u>10</u>												
	2013	<u>32,298</u>	<u>11</u>												
	2014	<u>32,672</u>	<u>12</u>												
2015 Accrual = \$32,672 x 1.03 = \$33,652															
Allocation from Double You = \$2,914															

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.

Facility Name & ID Number Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,478 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (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. (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).

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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	<u>Facility</u>	<u>41,400</u>	<u>1994</u>	<u>\$ 100,000</u>	<u>1</u>
2	<u>Allocated from Double You</u>		<u>2003</u>	<u>5,792</u>	<u>2</u>
3	TOTALS	41,400		\$ 105,792	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	82	1994	1976	\$ 2,293,000	\$ 59,827	35	\$ 65,514	\$ 5,687	\$ 1,382,627	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various	1994		7,258		20			7,258	9
10	Various	1995		41,235		20	943	943	34,660	10
11	Various	1996		14,284		20	714	714	13,405	11
12	Various	1997		19,228		20	961	961	17,743	12
13	Various	1998		8,781		20	439	439	7,814	13
14	Various	1999		74,013		20	2,105	2,105	34,035	14
15	Various	2000		16,733		20	837	837	12,805	15
16	Various	2001		3,412		20	171	171	2,519	16
17	Various	2002		100,056		20			100,056	17
18	Various	2003		172,044		20	1,818	1,818	160,594	18
19	Various	2004		17,406		20	870	870	9,864	19
20	Various	2005		31,352		20	306	306	31,352	20
21	Various	2006		1,000		20	100	100	1,000	21
22	Various	2007		23,100		20	2,310	2,310	19,204	22
23	Various	2008		15,797		20	1,580	1,580	11,850	23
24	Various	2009		6,310		20	631	631	4,145	24
25	Various	2010		27,030		20	2,184	2,184	11,641	25
26	Various	2011		74,494		20	5,599	5,599	25,521	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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			57,924	1,419	1,548	129	20,005	68				
69				22,027		(22,027)		69				
70		\$	3,004,458	\$	83,273	\$	88,630	\$	5,357	\$	1,908,098	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,004,458	\$ 83,273		\$ 88,630	\$ 5,357	\$ 1,908,098	1
2	Laundry Room Water Heater	2012	7,409		20	617	617	2,367	2
3	Dining Room Heating Cooling Rooftop	2012	10,700		20	274	274	880	3
4	Water Heater For Kitchen	2013	8,215		20	685	685	2,054	4
5	Ventilation System	2013	32,000		20	3,200	3,200	7,467	5
6	Walk-In Freezer	2013	6,699		20	447	447	1,265	6
7	Set Back East Elevation 2Nd Flr, Replace Brick, Tuck Point Eleva	2013	18,783		20	1,878	1,878	4,383	7
8	Installed Sprinkler System In Entire Facility	2013	75,000		20	7,500	7,500	17,500	8
9	Install Drywall In Rms And Bathrms 101-105, 109-112, 114,115, 20	2013	17,750		20	1,775	1,775	3,698	9
10	Dining Rm-Millwork Base, Cornice, Sheers, Wallcovering, Crashr	2014	17,720		20	886	886	1,255	10
11	Reroof Dining Area, Waterproof Walls & Windows	2014	13,950		20	698	698	814	11
12	Critical Panel Installation	2014	3,150		20	158	158	184	12
13	Install Condenser Outside For Walk-In Freezer	2014	5,000		20	250	250	438	13
14	Domestic Water Mixing Valve	2014	2,513		20	126	126	241	14
15	Elevator Shunt Trip	2015	5,000		20	188	188	188	15
16	Load Center Circuit Breaker For Backup Generator	2015	10,000		20	500	500	500	16
17	14 Square Of Sidewalk With New Concrete	2015	5,600		20	280	280	280	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	TOTAL (lines 1 thru 33)		\$ 3,243,948	\$ 83,273		\$ 108,091	\$ 24,818	\$ 1,951,610	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,243,948	\$ 83,273		\$ 108,091	\$ 24,818	\$ 1,951,610	1
2								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,243,948	\$ 83,273		\$ 108,091	\$ 24,818	\$ 1,951,610	34

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

Facility Name & ID Number Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,243,948	\$ 83,273		\$ 108,091	\$ 24,818	\$ 1,951,610	1
2								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,243,948	\$ 83,273		\$ 108,091	\$ 24,818	\$ 1,951,610	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,243,948	\$ 83,273		\$ 108,091	\$ 24,818	\$ 1,951,610	1
2								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,243,948	\$ 83,273		\$ 108,091	\$ 24,818	\$ 1,951,610	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

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	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Double You Realty	2003	55,360	1,419	20	1,420	1	18,395	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Stavcare	2003	2,564		20	128	128	1,610	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	TOTAL (lines 1 thru 33)		\$ 57,924	\$ 1,419		\$ 1,548	\$ 129	\$ 20,005	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 57,924	\$ 1,419		\$ 1,548	\$ 129	\$ 20,005	1
2								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 57,924	\$ 1,419		\$ 1,548	\$ 129	\$ 20,005	34

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

Facility Name & ID Number Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 103,388	\$	\$ 15,397	\$ 15,397	10	\$ 59,461	71
72	Current Year Purchases	8,806		1,027	1,027	10	1,027	72
73	Fully Depreciated Assets	70,459				10	70,459	73
74								74
75	TOTALS	\$ 182,653	\$	\$ 16,424	\$ 16,424		\$ 130,947	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		Allocated from Staycare	2012	\$ 3,920	\$ 268	\$ 505	\$ 237	5	\$ 2,070	76
77										77
78										78
79										79
80	TOTALS			\$ 3,920	\$ 268	\$ 505	\$ 237		\$ 2,070	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)	\$ 3,536,312	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 83,541	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,020	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 41,479	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,084,627	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		\$	\$	\$	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.

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? YES NO

If NO, see instructions.

		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								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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: \$ 4,202 Description: See Attached Schedule

(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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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. 2016 \$ _____

13. 2017 \$ _____

14. 2018 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Staff		Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	90,552	\$			\$	90,552	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				21,584					21,584	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs				106,294					106,294	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	39 - 02	# of prescripts						49,280			49,280	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify):												12
13	Other (specify): <u>See Supplemental</u>												13
14	TOTAL			\$		\$	218,430	\$	49,280	\$		267,710	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 Abbington Rehab And Nursing# 0039693Report Period Beginning: 01/01/15Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(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	\$ 630,896	\$ 690,739	1
2	Cash-Patient Deposits	20,762	20,762	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	504,112	504,112	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,558	96,558	6
7	Other Prepaid Expenses	1,990	1,990	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,254,318	\$ 1,314,161	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		101,756	13
14	Buildings, at Historical Cost		2,333,258	14
15	Leasehold Improvements, at Historical Cost	633,812	633,812	15
16	Equipment, at Historical Cost	224,497	331,497	16
17	Accumulated Depreciation (book methods)	(497,754)	(1,873,620)	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):	120,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 480,555	\$ 1,526,703	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,734,873	\$ 2,840,864	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 216,719	\$ 216,719	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,762	20,762	28
29	Short-Term Notes Payable	106,448		29
30	Accrued Salaries Payable	110,880	110,880	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,255	1,255	31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,653	33,653	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	2,497	2,497	35
Other Current Liabilities(specify):				
36	See Attached Schedule	53,808	53,808	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 546,022	\$ 439,574	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 546,022	\$ 439,574	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,188,851	\$ 2,401,290	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,734,873	\$ 2,840,864	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,834,279	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,834,276	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	502,575	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	(1,148,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (645,425)	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)	\$ 1,188,851	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Abbington Rehab And Nursing**# **0039693**Report Period Beginning: **01/01/15**

Ending:

12/31/15**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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,661,603	1
2	Discounts and Allowances for all Levels	(416,990)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,244,613	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	455,698	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 455,698	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	48,439	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,078	19
20	Radiology and X-Ray		20
21	Other Medical Services	6,278	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 56,795	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,045	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,045	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	34	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 34	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,759,185	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	726,884	31
32	Health Care	1,434,944	32
33	General Administration	981,371	33
B. Capital Expense			
34	Ownership	643,085	34
C. Ancillary Expense			
35	Special Cost Centers	278,210	35
36	Provider Participation Fee	192,116	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,256,610	40
41	Income before Income Taxes (line 30 minus line 40)**	502,575	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 502,575	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,080,759	44
45	Private Pay - Net Inpatient Revenue	584,291	45
46	Medicare - Net Inpatient Revenue	579,563	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,244,613	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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.

Facility Name & ID Number Abbington Rehab And Nursing

0039693

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,744	2,032	\$ 73,529	\$ 36.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,063	13,361	380,522	28.48	3
4	Licensed Practical Nurses	5,392	5,756	136,069	23.64	4
5	CNAs & Orderlies	33,834	38,881	481,704	12.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,000	2,256	35,059	15.54	8
9	Activity Director	2,016	2,080	30,998	14.90	9
10	Activity Assistants	2,603	2,691	26,017	9.67	10
11	Social Service Workers	1,889	2,081	35,517	17.07	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,080	31,631	15.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,284	12,722	138,500	10.89	15
16	Dishwashers					16
17	Maintenance Workers	1,832	2,064	50,505	24.47	17
18	Housekeepers	10,315	11,503	122,546	10.65	18
19	Laundry	2,025	2,273	27,312	12.02	19
20	Administrator	2,000	2,080	93,168	44.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,141	5,350	67,075	12.54	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 Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,976	4,216	141,046	33.45	33
34	TOTAL (lines 1 - 33)	100,066	111,426	\$ 1,871,198 *	\$ 16.79	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 6,936	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,755	10-03	39
40	Physical Therapy Consultant	8	382	10a-03	40
41	Occupational Therapy Consultant	2	79	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	79	10a-03	43
44	Activity Consultant	20	1,080	11-03	44
45	Social Service Consultant	39	2,082	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	71	\$ 22,393		49

C. CONTRACT NURSES

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

Facility Name & ID Number Abbington Rehab And Nursing

0039693

Report Period Beginning: 01/01/15

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Janet Cantelo	Administrator	0	\$ 93,168	Workers' Compensation Insurance	\$ 49,772	IDPH License Fee	\$	
				Unemployment Compensation Insurance	13,552	Advertising: Employee Recruitment	744	
				FICA Taxes	132,357	Health Care Worker Background Check	2,300	
				Employee Health Insurance	85,148	(Indicate # of checks performed <u>230</u>)		
				Employee Meals	7,939	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		License/Permits and Fees	3,141	
				Christmas Expense	500	Advertising and Promotion	7,311	
				Employee Benefits	922	ICLTC	5,917	
				Union Pension Expense	14,442	Allocated from Staycare	26	
				401K	1,345			
						Less: Public Relations Expense	()	
						Non-allowable advertising	(1,052)	
						Yellow page advertising	(6,259)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,168	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 305,977		\$ 12,129		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Staycare Management Fees			\$ 296,675			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 296,675				Seminar Expense	734
							Allocated from Staycare	109
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 62,697	TOTAL		\$	TOTAL	\$ 843

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Abbington Rehab And Nursing# 0039693

Report Period Beginning:

01/01/15

Ending:

12/31/15**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? Yes
If YES, give association name and amount. ICLTC \$8,831
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,663 Line 10
- (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. \$ 192,116
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. \$ 7,939 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? None
d. Have vehicle usage logs been maintained? N/A
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 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.