

Facility Name & ID Number Asbury Gardens Nrsg & Rehab

0051193 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	<u>75</u>	Skilled (SNF)	<u>75</u>	<u>27,375</u>	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	<u>75</u>	TOTALS	<u>75</u>	<u>27,375</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,248</u>	<u>1,413</u>	<u>4,691</u>	<u>7,352</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,248</u>	<u>1,413</u>	<u>4,691</u>	<u>7,352</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 26.86%

D. How many bed-hold days during this year were paid by the Department?

N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES 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

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

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 75 and days of care provided 3,073

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

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	80,033	22,085	11,320	113,438		113,438	113,438		1	
2	Food Purchase		39,498		39,498		39,498	39,498		2	
3	Housekeeping	56,121	20,053	1,626	77,800		77,800	77,800		3	
4	Laundry			34,229	34,229		34,229	34,229		4	
5	Heat and Other Utilities			70,889	70,889		70,889	70,889		5	
6	Maintenance	40,783	24,727	109,387	174,897		174,897	174,897		6	
7	Other (specify):*									7	
8	TOTAL General Services	176,937	106,363	227,451	510,751		510,751	510,751		8	
	B. Health Care and Programs										
9	Medical Director									9	
10	Nursing and Medical Records	775,680	59,334	143,319	978,333		978,333	978,333		10	
10a	Therapy									10a	
11	Activities									11	
12	Social Services	64,189	3,217	4,346	71,752		71,752	71,752		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	839,869	62,551	147,665	1,050,085		1,050,085	1,050,085		16	
	C. General Administration										
17	Administrative	288,346		215,135	503,481		503,481	(215,135)	288,346	17	
18	Directors Fees									18	
19	Professional Services			30,912	30,912		30,912	(2,833)	28,079	19	
20	Dues, Fees, Subscriptions & Promotions			50,510	50,510		50,510	1	50,511	20	
21	Clerical & General Office Expenses	186,689	20,715	1,438	208,842		208,842	90,985	299,827	21	
22	Employee Benefits & Payroll Taxes			167,489	167,489		167,489		167,489	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			7,269	7,269		7,269	(3,278)	3,991	24	
25	Other Admin. Staff Transportation			2,419	2,419		2,419	6,146	8,565	25	
26	Insurance-Prop.Liab.Malpractice			13,160	13,160		13,160	7,967	21,127	26	
27	Other (specify):* Mgmt. Co. Benefits							8,888	8,888	27	
28	TOTAL General Administration	475,035	20,715	488,332	984,082		984,082	(107,259)	876,823	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,491,841	189,629	863,448	2,544,918		2,544,918	(107,259)	2,437,659	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.

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							223,291	223,291			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							199,322	199,322			32
33	Real Estate Taxes							17,387	17,387			33
34	Rent-Facility & Grounds			312,000	312,000		312,000	(309,668)	2,332			34
35	Rent-Equipment & Vehicles			30,861	30,861		30,861		30,861			35
36	Other (specify):*											36
37	TOTAL Ownership			342,861	342,861		342,861	130,332	473,193			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		187,687	384,410	572,097		572,097		572,097			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,793	36,793		36,793		36,793			42
43	Other (specify):* Non-Allowable Co	9,750		98,844	108,594		108,594	(108,594)				43
44	TOTAL Special Cost Centers	9,750	187,687	520,047	717,484		717,484	(108,594)	608,890			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,501,591	377,316	1,726,356	3,605,263		3,605,263	(85,521)	3,519,742			45

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

Facility Name & ID Number Asbury Gardens Nrsng & Rehab

0051193

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	62,821	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,536)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,592)	43		24
25	Fund Raising, Advertising and Promotional	(62,024)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(26,286)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (50,617)		\$	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	2	
		Amount	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)	(34,904)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (34,904)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (85,521)		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	2	3	4	
		Yes	No	Amount	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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Asbury Gardens Nrsg & Rehab

ID# 0051193

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Misc. Income	\$ 841	21	1
2	Labs - Part A	(9,187)	43	2
3	X-Rays - Part A	(6,318)	43	3
4	Marketing Salaries	(9,750)	43	4
5	Consolidated Billing MD Visits	(279)	43	5
6	Adjust RE taxes	2,129	33	6
7	Non-Allowable Travel	(3,278)	24	7
8	Wound Care	(444)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(26,286)	49

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. 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	19 Professional Fees	\$	EJR Enterprises, Inc.	60.00%	\$ 1,703	\$ 1,703	1
2	V	21 Miscellaneous	51	EJR Enterprises, Inc.	60.00%	4	(47)	2
3	V	21 Bank Service Charges		EJR Enterprises, Inc.	60.00%	257	257	3
4	V	26 Property Insurance Exp		EJR Enterprises, Inc.	60.00%	7,267	7,267	4
5	V	30 Amortization Expense		EJR Enterprises, Inc.	60.00%	5,675	5,675	5
6	V	30 Depreciation Expense		EJR Enterprises, Inc.	60.00%	160,470	160,470	6
7	V	32 Closing Costs		EJR Enterprises, Inc.	60.00%	27,687	27,687	7
8	V	32 Interest: SNF Loan Int Exp	356	EJR Enterprises, Inc.	60.00%	166,316	165,960	8
9	V	33 Taxes - Property		EJR Enterprises, Inc.	60.00%	15,258	15,258	9
10	V	34 Rent	312,000	EJR Enterprises, Inc.	60.00%		(312,000)	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 312,407			\$ 384,637	\$ * 72,230	14

* 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 Dietary	\$ 102,788	Asbury Gardens SLF, LLC	60.00%	\$ 102,788	\$
16	V	2 Food	47,723	Asbury Gardens SLF, LLC	60.00%	47,723	
17	V	3 Housekeeping	28,732	Asbury Gardens SLF, LLC	60.00%	28,732	
18	V	5 Utilities	52,944	Asbury Gardens SLF, LLC	60.00%	52,944	
19	V	6 Repairs & Maintenance	123,768	Asbury Gardens SLF, LLC	60.00%	123,768	
20	V	20 Dues and Subscriptions	4,347	Asbury Gardens SLF, LLC	60.00%	4,347	
21	V	21 Telephone	5,211	Asbury Gardens SLF, LLC	60.00%	5,211	
22	V	35 Equipment Rental	41	Asbury Gardens SLF, LLC	60.00%	41	
23	V	43 Advertising	12,804	Asbury Gardens SLF, LLC	60.00%	12,804	
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 378,358			\$ 378,358	\$ * 0

* 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	17 Management Fees	\$ 215,135	Asbury Healthcare	60.00%	\$ 1	\$ (215,135)
16	V	20 Dues, Fees, & Subscriptions		Asbury Healthcare	60.00%	1	1
17	V	21 Administrative Salaries	18,708	Asbury Healthcare	60.00%	107,770	89,062
18	V	21 Office Supplies		Asbury Healthcare	60.00%	872	872
19	V	25 Auto Expense		Asbury Healthcare	60.00%	6,146	6,146
20	V	26 Insurance		Asbury Healthcare	60.00%	700	700
21	V	27 Mgmt. Alloc. - EE Benefits (Health)		Asbury Healthcare	60.00%	8,759	8,759
22	V	27 Mgmt. Alloc. - EE Benefits (W/C)		Asbury Healthcare	60.00%	129	129
23	V	34 Rent Expense		Asbury Healthcare	60.00%	2,332	2,332
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 233,843			\$ 126,709	\$ * (107,134)

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

Facility Name & ID Number Asbury Gardens Nrsg & Rehab # 0051193 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Asbury Gardens Nrsg & Rehab

0051193

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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

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

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	Dietary Salaries	Direct Cost	1	\$ 32,460	\$ 32,460	1	\$ 44,052	1
2	1	Dietary Supplies	Direct Cost	1	10,820		1	14,684	2
3	1	Dietary Temp Help	Direct Cost	1	32,460		1	44,052	3
4	2	Food	Direct Cost	1	35,165		1	47,723	4
5	3	Housekeeping Salaries	Total Beds / Units	298	114,163	114,163	75	28,732	5
6	5	Electric	Total Beds / Units	298	127,653	127,653	75	32,127	6
7	5	Gas	Total Beds / Units	298	47,789	47,789	75	12,027	7
8	5	Water and Sewer	Total Beds / Units	298	34,927	34,927	75	8,790	8
9	6	Dietary Repairs & Maintenance	Direct Cost	1	135		1	179	9
10	6	Maintenance Salaries	Total Beds / Units	298	195,395	195,395	75	49,177	10
11	6	Waste Removal	Total Beds / Units	298	27,907	27,907	75	7,024	11
12	6	Exterminating	Total Beds / Units	298	6,164	6,164	75	1,551	12
13	6	Maintenance Outside Service	Total Beds / Units	298	218,089	218,089	75	54,888	13
14	6	Snow Removal/Landscaping	Total Beds / Units	298	43,503	43,503	75	10,949	14
15	20	Permits	Total Beds / Units	298	5,769	5,769	75	1,452	15
16	20	Dues and Subscriptions	Total Beds / Units	298	11,503	11,503	75	2,895	16
17	21	Telephone	Total Beds / Units	298	20,706	20,706	75	5,211	17
18	35	Dietary Equipment Rental	Direct Cost	1	31		1	41	18
19	43	Advertising	Total Beds / Units	298	50,875	50,875	75	12,804	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,015,514	\$ 936,903		\$ 378,358	25

Facility Name & ID Number Asbury Gardens Nrsg & Rehab

0051193

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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

Name of Related Organization Asbury Healthcare
 Street Address 8170 McCormick Blvd., Suite 104
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 676-1700
 Fax Number (847) 675-1700

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	20	Dues, Fees, & Subscriptions	Bed Days Available	244,915	3	\$ 10	\$ 27,375	\$ 1	1
2	21	Administrative Salaries	Bed Days Available	244,915	3	964,178	27,375	107,770	2
3	21	Office Supplies	Bed Days Available	244,915	3	7,801	27,375	872	3
4	25	Auto Expense	Bed Days Available	244,915	3	54,988	27,375	6,146	4
5	26	Insurance	Bed Days Available	244,915	3	6,259	27,375	700	5
6	27	Mgmt. Alloc. - EE Benefits (Health)	Bed Days Available	244,915	3	78,360	27,375	8,759	6
7	27	Mgmt. Alloc. - EE Benefits (W/C)	Bed Days Available	244,915	3	1,151	27,375	129	7
8	34	Rent Expense	Bed Days Available	244,915	3	20,863	27,375	2,332	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					\$ 1,133,610	\$	\$ 126,709	25

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	Name of Lender	2		3	4	5	6		8	9	10						
		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	Bank Leumi		X	Construction / Mortgage	\$25,275.32	3/19/13	\$ 4,135,000	\$ 3,762,436	6/15/16	0.0428	\$ 165,960	1					
2	Allocated from RE Entity - Amortization										5,675	2					
3	Allocated from RE Entity - Closing Costs										27,687	3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$25,275.32		\$ 4,135,000	\$ 3,762,436			\$ 199,322	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 4,135,000	\$ 3,762,436			\$ 199,322	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

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.				\$	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.)	2014			\$	17,387 2										
3. Under or (over) accrual (line 2 minus line 1).				\$	17,387 3										
4. Real Estate Tax accrual used for 2015 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										
		Allocated from Management Co.													
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	17,387 7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	_____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$ _____ 13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____ 14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$ _____ 15</td> </tr> <tr> <td>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	_____	9												
	2012	<u>8,025</u>	10												
	2013	<u>8,940</u>	11												
	2014	<u>17,387</u>	12												
<u>Facility does not accrue real estate taxes.</u>															

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.

2014 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 2014 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 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-04-451-010</u>	<u>Skilled Nursing Facility</u>	\$ <u>17,386.88</u>	\$ <u>17,386.88</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>17,386.88</u></u>	\$ <u><u>17,386.88</u></u>

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.**

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 (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).

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 Apartment

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: 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	
	<u>Resident Care</u>	<u>56,241</u>	<u>1986</u>	<u>\$ 189,466</u>	<u>1</u>
					<u>2</u>
	TOTALS	56,241		\$ 189,466	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	75			2013	\$ 4,760,004	\$	40	\$ 119,000	\$ 119,000	\$ 178,500
5										
6										
7										
8										
	Improvement Type**									
9		Utility Building - Hot Water, Data, Telephone & Electrical		2010	168,592		40	4,215	4,215	23,182
10										
11		Excavate & Install new Sidewalk - West Side of Building		2014	3,800		15	253	253	380
12										
13		Patch, prime & paint walls around AC units outside; replace 5 locks		2015	2,750		15	92	92	92
14		Relocate main water line and sprinkler in nursing home		2015	6,900		15	230	230	230
15										
16		Installation of digital television capabilities throughout facility		2015	15,381		15	513	513	513
17		Install shelves to the walls and wiring								
18										
19		R/M Reclss - Plumbing: HydroJett Sewer Service; Root Intrusion		2015	12,080		15	403	403	403
20										
21		R/M Reclss - Install indoor/outdoor keypad locks & programming		2015	3,898		15	130	130	130
22		with alarm system - Nursing & Rehabilitation wing - 212 Building doors								
23										
24		R/M Reclss - Circuit room Battery Replacement - 2 8D Batteries		2015	2,784		5	278	278	278
25										
26		R/M Reclss - Mechanical repairs to rooftop units; modified roof ductwork		2015	17,673		15	589	589	589
27										
28		R/M Reclss - Repair to RTU electrical room, replaced ignition board.		2015	3,055		15	102	102	102
29		Washed coils, repaired disconnected heat and power								
30										
31		Dining Room - Install back wall, install paneling and corner guards		2015	6,420		15	214	214	214
32		Relocate electrical and water line for new equipment								
33										
34		Electrical Room - Installed one Energy meter for the ATS, install wire		2015	2,560		15	85	85	85
35		mounting hardware								
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Asbury Gardens Nrsg & Rehab

0051193

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,005,897	\$		\$ 126,103	\$ 126,103	\$ 204,697	70

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

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	\$ 474,880	\$	\$ 94,976	\$ 94,976	5	\$ 142,464	71
72	Current Year Purchases	22,116		2,212	2,212	5	2,212	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 496,996	\$	\$ 97,188	\$ 97,188		\$ 144,676	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)	\$ 5,692,359	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)	\$ 223,291	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 223,291	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 349,373	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.

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	<u>Allocated from Management Company</u>				<u>2332.00</u>			6
7	TOTAL				\$ <u>2,332</u>			7

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 \$ _____

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 _____.

N/A

N/A

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

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: \$ 30,861 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			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name: Asbury Gardens Nrsg & Rehab
IDPH License ID Number: 0051193
Fiscal Year End: 12/31/2015

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Beds	3,084
Mattress	5,783
Nebulizer	181
Oxygen	50
Patient Lift	150
Sling	23
Wheelchair	2,955
Commode	855
Therapy Equipment	17,780
Total - Line 16	30,861

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	\$ N/A	\$	\$	\$ #VALUE!
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	\$	\$	\$	\$ #VALUE!
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	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	L39(2)(3)	hrs	\$	2,151	\$ 122,587	\$ 484	2,151	\$ 123,071	1	
2	Licensed Speech and Language Development Therapist	L39(2)(3)	hrs		954	54,350	215	954	54,565	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	L39(2)(3)	hrs		3,513	200,256	788	3,513	201,044	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				183,406		183,406	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	L39(3)	hrs			134			134	10	
11	Academic Education		hrs							11	
12	Other (specify): <u>Oxygen</u>	L39(2)					2,794		2,794	12	
13	Other (specify): <u>Ambulance</u>	L39(3)				7,083			7,083	13	
14	TOTAL			\$	6,618	\$ 384,410	\$ 187,687	6,618	\$ 572,097	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 Gardens Nrsrg & Rehab# 0051193Report Period Beginning: 1/1/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(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	\$ 16,505	\$ 16,505	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>-0-</u>)	966,530	966,530	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	35,446	35,446	7
8	Accounts Receivable (owners or related parties)	103,354	103,354	8
9	Other(specify): <u>See Sch. 17A</u>	6,350	6,350	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,128,185	\$ 1,128,185	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		245,893	15
16	Equipment, at Historical Cost		496,996	16
17	Accumulated Depreciation (book methods)		(349,373)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: _____)			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 5,342,986	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,128,185	\$ 6,471,171	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 166,408	\$ 166,408	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,734	44,734	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	<u>See Schedule 17A</u>	3,080,387	3,080,387	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,291,529	\$ 3,291,529	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,762,436	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)	\$	\$ 3,762,436	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,291,529	\$ 7,053,965	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,163,344)	\$ (582,794)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,128,185	\$ 6,471,171	48

*(See instructions.)

Facility Name: Asbury Gardens Nrsng & Rehab
IDPH License ID Number: 0051193
Fiscal Year End: 12/31/2015

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
Exchange Clearing Account	3,348	3,348
ADP Manual Checks Clearing Acc	1,000	1,000
Medicare Settlement	966	966
Medicaid Settlement	1,036	1,036
Total - Line 9	6,350	6,350

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Payroll Liabilities (401) K withholding Acc	(185)	(185)
Payroll Liabilities Dental Insurance W/H	(250)	(250)
Payroll Liabilities Supplemental Insurance W/H	(237)	(237)
Medicaid Holding Account	(16,349)	(16,349)
2050 · Due to Asbury Gardens	(2,385,012)	(2,385,012)
Management Fee Payable	(215,135)	(215,135)
Rent Payable	(312,000)	(312,000)
Due to Asbury Court	(95,900)	(95,900)
Due to Asbury Healthcare	(25,638)	(25,638)
Refunds Due/Clearing Account	5,800	5,800
Due to Ashley Management	(35,481)	(35,481)
Total - Line 36	(3,080,387)	(3,080,387)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,246,789)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(474)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,247,263)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(916,081)	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)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (916,081)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,163,344)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Asbury Gardens Nrsng & Rehab# 0051193Report Period Beginning: 1/1/2015Ending: 12/31/2015

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,668,075	1
2	Discounts and Allowances for all Levels	(17,560)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,650,515	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	39,508	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 39,508	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		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc. Income</u>	(841)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (841)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,689,182	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	510,751	31
32	Health Care	1,050,085	32
33	General Administration	984,082	33
B. Capital Expense			
34	Ownership	342,861	34
C. Ancillary Expense			
35	Special Cost Centers	680,691	35
36	Provider Participation Fee	36,793	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,605,263	40
41	Income before Income Taxes (line 30 minus line 40)**	(916,081)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (916,081)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 254,024	44
45	Private Pay - Net Inpatient Revenue	338,147	45
46	Medicare - Net Inpatient Revenue	1,452,416	46
47	Other-(specify) <u>Managed Care</u>	605,253	47
48	Other-(specify) <u>Medicaid Pending</u>	675	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,650,515	49

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

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

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

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

^ - This entity is a Cash Basis Tax Payer

Facility Name & ID Number Asbury Gardens Nrsg & Rehab

0051193

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	1,825	2,147	\$ 101,926	\$ 47.47	1
2	Assistant Director of Nursing	523	615	21,300	34.63	2
3	Registered Nurses	8,109	9,540	282,264	29.59	3
4	Licensed Practical Nurses	3,035	3,570	95,235	26.68	4
5	CNAs & Orderlies	17,093	20,109	274,955	13.67	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	2,596	3,055	64,189	21.01	11
12	Dietician					12
13	Food Service Supervisor	719	846	8,403	9.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,132	7,214	71,630	9.93	15
16	Dishwashers					16
17	Maintenance Workers	1,818	2,139	40,783	19.07	17
18	Housekeepers	5,294	6,228	56,121	9.01	18
19	Laundry					19
20	Administrator	2,557	3,008	288,346	95.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,999	8,234	186,689	22.67	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>Marketing</u>	252	297	9,750	32.83	33
34	TOTAL (lines 1 - 33)	56,952	67,002	\$ 1,501,591 *	\$ 22.41	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	\$ 7,234	1(3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	357	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 7,591		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	844	\$ 43,902	10(3)	50
51	Licensed Practical Nurses	468	19,645	10(3)	51
52	Certified Nurse Assistants/Aides	3,151	69,315	10(3)	52
53	TOTAL (lines 50 - 52)	4,463	\$ 132,862		53

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	
Robert Talbot	Administrator	0	\$ 220,846	Workers' Compensation Insurance	\$ 17,944	IDPH License Fee	\$ 3,980	
Christopher Raybory	Administrator	0	67,500	Unemployment Compensation Insurance		Advertising: Employee Recruitment	37,000	
				FICA Taxes	131,458	Health Care Worker Background Check		
				Employee Health Insurance	15,704	(Indicate # of checks performed <u>275</u>)	3,299	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	1,000	
				Other Employee Benefits	2,383	Miscellaneous Dues/Subscriptions	5,231	
						Allocated from Home Office	1	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 288,346					
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Management Fees - Asbury Healthcare			\$ 215,135			Yellow page advertising	()	
Eliminated in Col. 7								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 215,135	TOTAL (agree to Schedule V, line 22, col.8)	\$ 167,489	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 50,511	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Allen Lefkowitz	Legal		\$ 3,600	N/A			Out-of-State Travel	\$
Polsinelli PC	Legal		1,632					
RSM US LLP	Accounting		8,155				In-State Travel	
ADP	Payroll Processing		5,039					
PointClickCare	Clinical Software		9,848					
Emdeon	Billing Software		588					
Personnel Planners	U/C Consulting		660					
Dorado Systems, LLC	Computer Services		790				Seminar Expense	3,991
KBC	Computer Services		600					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 30,912	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 3,991

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Asbury Gardens Nrsg & Rehab
IDPH License ID Number: 0051193
Fiscal Year End: 12/31/2015

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
Professional Fees from Pg 21		30,912
	Total (agree to Schedule V, line 19, column 3)	<u>30,912</u>
Allocated from Real Estate Entity Professional Services		1,703
Less Non-Allowable Out of Period & Retainers		(4,536)
	Total (agree to Schedule V, line 19, column 8)	<u>28,079</u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												N/A
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Asbury Gardens Nrsg & Rehab# 0051193

Report Period Beginning:

1/1/2015

Ending:

12/31/2015**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? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,420 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. \$ 36,793
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. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.