

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: <u>0055012</u> Facility Name: <u>Asbury Court Nursing Rehab</u> Address: <u>1750 Elmhurst Road</u> <u>Des Plaines</u> <u>60018</u> Number City Zip Code County: <u>Cook</u> Telephone Number: <u>(847) 228-1500</u> Fax # <u>(847) 228-1579</u> HFS ID Number: _____ Date of Initial License for Current Owners: <u>8/16/2018</u> Type of Ownership: <table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table> In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____	☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____ (Date) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____ <u>05/05/2021</u></td></tr><tr><td>* Subject to the attached Accountants' Consulting Report (Date) _____</td></tr><tr><td>(Print Name <u>Steven N. Lavenda, CPA</u> and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Marcum, LLP</u> & Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr></table> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	(Title) _____	Paid Preparer	(Signed) _____ <u>05/05/2021</u>	* Subject to the attached Accountants' Consulting Report (Date) _____	(Print Name <u>Steven N. Lavenda, CPA</u> and Title) <u>Partner</u>	(Firm Name <u>Marcum, LLP</u> & Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
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Facility Name & ID Number Asbury Court Nursing Rehab

0055012 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 11/20/2020

	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>71</u>	Skilled (SNF)	<u>79</u>	<u>26,322</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>71</u>	TOTALS	<u>79</u>	<u>26,322</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>8,278</u>	<u>1,339</u>	<u>5,374</u>	<u>14,991</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>8,278</u>	<u>1,339</u>	<u>5,374</u>	<u>14,991</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 56.95%

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

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

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

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ 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 8/27/2018

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 79 and days of care provided 4,439

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: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Asbury Court Nursing Rehab # 0055012 Report Period Beginning: 01/01/20 Ending: 12/31/20
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	94,685	117	7,842	102,644		102,644		102,644			1
2	Food Purchase		91,245		91,245		91,245	(82)	91,163			2
3	Housekeeping	55,005			55,005		55,005		55,005			3
4	Laundry											4
5	Heat and Other Utilities			83,321	83,321		83,321	(5,566)	77,755			5
6	Maintenance			85,694	85,694		85,694		85,694			6
7	Other (specify):*											7
8	TOTAL General Services	149,690	91,362	176,857	417,909		417,909	(5,648)	412,261			8
	B. Health Care and Programs											
9	Medical Director			339	339		339		339			9
10	Nursing and Medical Records	1,647,228		159,238	1,806,466		1,806,466		1,806,466			10
10a	Therapy			300	300		300		300			10a
11	Activities		94,746		94,746		94,746		94,746			11
12	Social Services	57,528		808	58,336		58,336		58,336			12
13	CNA Training											13
14	Program Transportation			28,788	28,788		28,788		28,788			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,704,756	94,746	189,473	1,988,975		1,988,975		1,988,975			16
	C. General Administration											
17	Administrative	120,000		272,413	392,413		392,413	(272,413)	120,000			17
18	Directors Fees											18
19	Professional Services			291,680	291,680		291,680	(5,265)	286,415			19
20	Dues, Fees, Subscriptions & Promotions			94,084	94,084		94,084	(7,942)	86,142			20
21	Clerical & General Office Expenses	74,344	950	216,431	291,725		291,725	(120,403)	171,322			21
22	Employee Benefits & Payroll Taxes			259,330	259,330		259,330		259,330			22
23	Inservice Training & Education											23
24	Travel and Seminar			349	349		349		349			24
25	Other Admin. Staff Transportation							2,056	2,056			25
26	Insurance-Prop.Liab.Malpractice			137,095	137,095		137,095	11,267	148,362			26
27	Other (specify):*							8,184	8,184			27
28	TOTAL General Administration	194,344	950	1,271,382	1,466,676		1,466,676	(384,516)	1,082,160			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,048,790	187,058	1,637,712	3,873,560		3,873,560	(390,164)	3,483,396			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							271,604	271,604			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							551,950	551,950			32
33	Real Estate Taxes							100,436	100,436			33
34	Rent-Facility & Grounds			995,702	995,702		995,702	(991,082)	4,620			34
35	Rent-Equipment & Vehicles			11,225	11,225		11,225		11,225			35
36	Other (specify):*							86,493	86,493			36
37	TOTAL Ownership			1,006,927	1,006,927		1,006,927	19,401	1,026,328			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		211,065	813,405	1,024,470		1,024,470		1,024,470			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			4,862	4,862		4,862	(4,862)	0			41
42	Provider Participation Fee			89,968	89,968		89,968		89,968			42
43	Other (specify):*	71,639		27,883	99,522		99,522	(99,522)	(0)			43
44	TOTAL Special Cost Centers	71,639	211,065	936,118	1,218,822		1,218,822	(104,384)	1,114,438			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,120,429	398,123	3,580,757	6,099,309		6,099,309	(475,147)	5,624,162			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,566)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,265)	30		9
10	Interest and Other Investment Income	(4,131)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(82)	02		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	(810)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(167,362)	21		24
25	Fund Raising, Advertising and Promotional	(5,221)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,636)	20		28
29	Other-Attach Schedule	(186,697)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (402,770)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(72,377)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (72,377)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (475,147)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sequestration	\$ (19,063)	21	1
2	Bank Service Charge	(3,924)	21	2
3	Marketing Salaries	(71,639)	43	3
4	Digital Media	(12,238)	43	4
5	Promotions	(31)	43	5
6	Building Co - Bank Service	(2)	21	6
7	Building Co - Professional Fees	(34,278)	19	7
8	Building Co - License and Permits	(74)	20	8
9	Building Co - Amortization	(12,556)	36	9
10	Starbucks Revenue	(4,862)	41	10
11	Miscellaneous Income	(5,816)	21	11
12	Non-Allowable Legal	(6,600)	19	12
13	Marketing Expense	(282)	43	13
14	Marketing Fee	(15,332)	43	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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24				24
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(186,697)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Asbury Court Nursing Rehab

0055012

Report Period Beginning:

01/01/20

Ending:

12/31/20

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													1
2	Food Purchase	(82)											(82)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,566)											(5,566)	5
6	Maintenance													6
7	Other (specify):*													7
8	TOTAL General Services	(5,648)											(5,648)	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				(272,413)								(272,413)	17
18	Directors Fees													18
19	Professional Services	(40,878)	34,278		1,335								(5,265)	19
20	Fees, Subscriptions & Promotions	(10,931)	74		2,915								(7,942)	20
21	Clerical & General Office Expenses	(196,977)	2		76,572								(120,403)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation				2,056								2,056	25
26	Insurance-Prop.Liab.Malpractice		10,738		529								11,267	26
27	Other (specify):*				8,184								8,184	27
28	TOTAL General Administration	(248,786)	45,092		(180,822)								(384,516)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(254,434)	45,092		(180,822)								(390,164)	29

Summary B

12/31/20

[illegible]

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	\$ 995,702	Des Plaines Property		\$	(995,702)	1
2	V	32	Interest	1,766	Des Plaines Property		557,847	556,081	2
3	V	26	Insurance		Des Plaines Property		10,738	10,738	3
4	V	21	Bank Service		Des Plaines Property		2	2	4
5	V	19	Professional Fees		Des Plaines Property		34,278	34,278	5
6	V	20	License and Permits		Des Plaines Property		74	74	6
7	V	33	Real Estate Taxes		Des Plaines Property		100,436	100,436	7
8	V	36	MIP Expense		Des Plaines Property		86,493	86,493	8
9	V	30	Depreciation		Des Plaines Property		298,869	298,869	9
10	V	36	Amortization		Des Plaines Property		12,556	12,556	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 997,468			\$ 1,101,293	\$ * 103,825	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ABRAHAM DIAMOND	16.67%	ASBURY PAVILION NURSING AND REHABILITATION	NORTH AURORA	DES PLAINES PROPERTY LLC	DES PLAINES	BUILDING COMPANY	1
2	MOSHE KAHN	16.67%			ASBURY HEALTHCARE	SKOKIE	MANAGEMENT COMPANY	2
3	SHOSANA KAHN	16.67%			ASBURY COURT SLF	DES PLAINES	SUPPORTIVE LIVING	3
4	SAMUEL SELESKI	16.67%			ASBURY GARDENS	NORTH AURORA	SUPPORTIVE LIVING	4
5	RACHEL DIAMOND	16.67%			EJR ENTERPRISE	SKOKIE	BUILDING COMPANY	5
6	MIRIAM SELESKI	16.67%			ASBURY OF KANKAKEE	KANKAKEE	SUPPORTIVE LIVING	6
7					MORaine COURT	BRIDGEVIEW	SUPPORTIVE LIVING	7
8					BETHEL SLF	CHICAGO	SUPPORTIVE LIVING	8
9								9
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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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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

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	01	Dietary Supplies	\$ 17,086	Asbury Court SLF		\$ 17,086	\$	15
16	V	01	Dietary Salaries	84,634	Asbury Court SLF		84,634		16
17	V	02	Food	91,340	Asbury Court SLF		91,340		17
18	V	03	Housekeeping Supplies	10,286	Asbury Court SLF		10,286		18
19	V	03	Housekeeper Salaries	25,926	Asbury Court SLF		25,926		19
20	V	05	Utilities	46,719	Asbury Court SLF		46,719		20
21	V	06	Repairs and Maintenance	41,533	Asbury Court SLF		41,533		21
22	V	06	Scavenger	4,695	Asbury Court SLF		4,695		22
23	V	10	Temporary Help	4,364	Asbury Court SLF		4,364		23
24	V	11	Activities Supplies	1,437	Asbury Court SLF		1,437		24
25	V	20	Dues and Subscriptions	60	Asbury Court SLF		60		25
26	V	21	Office Expense	11,561	Asbury Court SLF		11,561		26
27	V	21	Campus Supplies	311	Asbury Court SLF		311		27
28	V	35	Dietary Equipment Rental	117	Asbury Court SLF		117		28
29	V	43	Marketing	6,564	Asbury Court SLF		6,564		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			\$ 346,633			\$ 346,633	\$ *	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	19	Professional Fees	\$	Asbury Healthcare		\$ 1,335	\$ 1,335	15
16	V	20	License and Permits		Asbury Healthcare		27	27	16
17	V	20	Personnel Recruitment		Asbury Healthcare		2,888	2,888	17
18	V	21	A&G Wages		Asbury Healthcare		74,403	74,403	18
19	V	21	Office Expenses		Asbury Healthcare		2,169	2,169	19
20	V	25	Travel		Asbury Healthcare		2,056	2,056	20
21	V	26	Insurance - General		Asbury Healthcare		529	529	21
22	V	27	Employee Benefits		Asbury Healthcare		8,184	8,184	22
23	V	34	Rent Expense		Asbury Healthcare		4,620	4,620	23
24	V	43	Marketing Salaries	9,435	Asbury Healthcare		9,435		24
25	V	19	Consulting Fee	84,534	Asbury Healthcare		84,534		25
26	V	19	Bookkeeping Fee	70,000	Asbury Healthcare		70,000		26
27	V	43	Marketing Fee	15,332	Asbury Healthcare		15,332		27
28	V	17	Management Fee	272,413	Asbury Healthcare			(272,413)	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			\$ 451,714			\$ 275,512	\$ * (176,202)	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.

YESNO

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			\$			\$	\$	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:	
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			\$			\$	\$	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:	
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			\$			\$	\$	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:	
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			\$			\$	\$	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:	
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			\$			\$	\$	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:	
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			\$			\$	\$	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:	
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			\$			\$	\$	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 Asbury Court Nursing Rehab # 0055012 Report Period Beginning: 01/01/20 Ending: 12/31/20

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											2
3											3
4											4
5											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	\$		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.

Ending: 12/31/20

Facility Name & ID Number Asbury Court Nursing Rehab# 0055012

Report Period Beginning:

01/01/20Ending: 12/31/20

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

Asbury Court SLF

Street Address

1750 S. Elmhurst Road

City / State / Zip Code

Des Plaines, IL 60018

Phone Number

(847) 228-1500

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	01	Dietary Supplies	Direct	1	\$ 126,160	\$		\$ 17,086	1
2	01	Dietary Salaries	Direct	1	636,617	636,617		84,634	2
3	02	Food	Direct	1	679,276			91,340	3
4	03	Housekeeping Supplies	Total Bed / Unit	444	64,321			10,286	4
5	03	Housekeeper Salaries	Total Bed / Unit	444	162,127	162,127		25,926	5
6	05	Utilities	Total Bed / Unit	444	292,157			46,719	6
7	06	Repairs and Maintenance	Total Bed / Unit	444	259,728			41,533	7
8	06	Scavenger	Direct	1	34,363			4,695	8
9	10	Temporary Help	Total Bed / Unit	444	27,293			4,364	9
10	11	Activities Supplies	Direct	1	8,562			1,437	10
11	20	Dues and Subscriptions	Total Bed / Unit	444	377			60	11
12	21	Office Expense	Total Bed / Unit	444	72,296			11,561	12
13	21	Campus Supplies	Direct	1	2,558			311	13
14	35	Dietary Equipment Rental	Total Bed / Unit	444	730			117	14
15	43	Marketing	Total Bed / Unit	444	41,050			6,564	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,407,616	\$ 798,744		\$ 346,633	25

Facility Name & ID Number Asbury Court Nursing Rehab# 0055012

Report Period Beginning:

01/01/20Ending: 12/31/20

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

Asbury Healthcare

Street Address

7040 N. Ridgeway Avenue

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 676 -1700

Fax Number

(847) 675-1700

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	19	Professional Fees	Available Bed Days	7	\$ 18,001	\$	28,914	\$ 1,335	1
2	20	License and Permits	Available Bed Days	7	369		28,914	27	2
3	20	Personnel Recruitment	Available Bed Days	7	38,936		28,914	2,888	3
4	21	A&G Wages	Available Bed Days	7	1,003,027	1,003,027	28,914	74,403	4
5	21	Office Expenses	Available Bed Days	7	29,245		28,914	2,169	5
6	25	Travel	Available Bed Days	7	27,721		28,914	2,056	6
7	26	Insurance - General	Available Bed Days	7	7,126		28,914	529	7
8	27	Employee Benefits	Available Bed Days	7	110,327		28,914	8,184	8
9	34	Rent Expense	Available Bed Days	7	62,288		28,914	4,620	9
10	43	Marketing Salaries	Direct	1	9,435	9,435	1	9,435	10
11	19	Consulting Fee	Direct	1	84,534		1	84,534	11
12	19	Bookkeeping Fee	Direct	1	70,000		1	70,000	12
13	43	Marketing Fee	Direct	1	15,332		1	15,332	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				\$ 1,476,341	\$ 1,012,462		\$ 275,512	25

Ending: 12/31/20

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

IL478-2471

Facility Name & ID Number Asbury Court Nursing Rehab # 0055012 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

Ending: 12/31/20

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

Ending: 12/31/20

Name of Related Organization

Fax Number

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

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

Ending: 12/31/20

Ending: 12/31/20**Fax Number**

Ending: 12/31/20

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

IL478-2471

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Capital One		X	Mortgage	\$221,219.00	4/1/2019	\$ 28,449,200	\$ 13,561,378	8/31/2053	0.0435	\$ 557,847	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$221,219.00		\$ 28,449,200	\$ 13,561,378			\$ 557,847	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,131)	10
11	Interest Income - Bldg Co		X								(1,766)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (5,897)	14
15	TOTALS (line 9+line14)						\$ 28,449,200	\$ 13,561,378			\$ 551,950	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 86,493 Line # 36

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Asbury Court Nursing Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055012

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 08-26-201-034-0000	Long Term Care Facility	\$ 153,264.35	\$ 153,264.35
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 153,264.35	\$ 153,264.35

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

FACILITY NAME Asbury Court Nursing Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055012

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

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

B. Real Estate Tax Cost Allocations

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.)

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

Page 10B

A. Square Feet: 46,535

B. General Construction Type: ExteriorMasonryFrameSteelNumber of Stories2

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).

Supportive Living Facility - 150 units, 179 beds

Memory Care Unit - 40 units, 52 beds

Assisted Living Facility - 114 units, 131 beds

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	56,930	1994	\$ 1,062,315	1
2					2
3	TOTALS	56,930		\$ 1,062,315	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	71			2018	\$ 7,120,730	\$ 298,869	35	\$ 203,449	\$ (95,420)	\$ 470,476	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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23											23
24											24
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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
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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		\$ 7,120,730	\$ 298,869		\$ 203,449	\$ (95,420)	\$ 470,476	70

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

Facility Name & ID Number Asbury Court Nursing Rehab

0055012

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	Totals from Page 12A, Carried Forward		\$ 7,120,730	\$ 298,869		\$ 203,449	\$ (95,420)	\$ 470,476	1
2	R/M: Install 220 V Receptacle, 2 Pole Circuit Breaker In Kitchen	2019	3,708		20	185	185	370	2
3	R/M: Install Electrical Feeder In Mechanical Room Main Circuit	2019	8,750		20	438	438	876	3
4									4
5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,133,188	\$ 298,869		\$ 204,072	\$ (94,797)	\$ 471,722	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	Totals from Page 12B, Carried Forward		\$ 7,133,188	\$ 298,869		\$ 204,072	\$ (94,797)	\$ 471,722	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,133,188	\$ 298,869		\$ 204,072	\$ (94,797)	\$ 471,722	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	Totals from Page 12C, Carried Forward		\$ 7,133,188	\$ 298,869		\$ 204,072	\$ (94,797)	\$ 471,722	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,133,188	\$ 298,869		\$ 204,072	\$ (94,797)	\$ 471,722	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	Totals from Page 12D, Carried Forward		\$7,133,188	\$298,869		\$204,072	\$(94,797)	\$471,722	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$7,133,188	\$298,869		\$204,072	\$(94,797)	\$471,722	34

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

Facility Name & ID Number Asbury Court Nursing Rehab

0055012

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	Building Company		\$	\$		\$	\$	\$	1
2									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
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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	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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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									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
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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	Totals from Page 12H, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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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)

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	\$664,378	\$	\$66,438	\$66,438	10	\$260,495	71
72	Current Year Purchases	10,935		1,094	1,094	10	1,094	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$675,313	\$	\$67,531	\$67,531		\$261,588	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$8,870,816	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$298,869	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$271,604	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(27,265)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$733,311	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?
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	Allocated from Asbury Healthcare				4,620			5
6								6
7	TOTAL				\$4,620			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: \$11,225
- Description: See Attached

(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.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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	

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

12 MONTH BUDGET										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		232,273	\$		232,273	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			52,524			52,524	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			247,417			247,417	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			216,049			216,049	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					65,142	211,065		276,207	13
14	TOTAL			\$		813,405	211,065		1,024,470	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,515,865	\$ 1,788,003	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,857,195	1,857,195	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,610	19,310	6
7	Other Prepaid Expenses	22,355	48,455	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	82,940	82,940	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,490,965	\$ 3,795,903	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,062,315	13
14	Buildings, at Historical Cost		7,120,730	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	78,977	694,050	16
17	Accumulated Depreciation (book methods)		(2,151,515)	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): See Attached		502,799	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 78,977	\$ 7,228,379	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,569,942	\$ 11,024,282	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 380,704	\$ 406,057	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60	60	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	28,940	28,940	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,191	3,191	31
32	Accrued Real Estate Taxes(Sch.IX-B)		142,110	32
33	Accrued Interest Payable		44,074	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	703,194	703,194	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,116,089	\$ 1,327,626	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,561,378	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	2,383,126	2,456,370	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,383,126	\$ 16,017,748	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,499,215	\$ 17,345,374	46
47	TOTAL EQUITY (page 18, line 24)	\$ 70,727	\$ (6,321,092)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,569,942	\$ 11,024,282	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 153,708	1
2	Restatements (describe):		2
3	Equity Restatement	(5,965)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 147,743	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(77,016)	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)	\$ (77,016)	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)	\$ 70,727	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Asbury Court Nursing Rehab

0055012

Report Period Beginning: 01/01/20

Ending: 12/31/20

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	\$ 5,341,134	1
2	Discounts and Allowances for all Levels	389	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,341,523	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	110,982	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 110,982	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	109	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)	\$ 109	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,131	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,131	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	565,548	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 565,548	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,022,293	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	417,909	31
32	Health Care	1,988,975	32
33	General Administration	1,466,676	33
	B. Capital Expense		
34	Ownership	1,006,927	34
	C. Ancillary Expense		
35	Special Cost Centers	1,128,854	35
36	Provider Participation Fee	89,968	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,099,309	40
41	Income before Income Taxes (line 30 minus line 40)**	(77,016)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (77,016)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 842,572	44
45	Private Pay - Net Inpatient Revenue	412,148	45
46	Medicare - Net Inpatient Revenue	2,699,162	46
47	Other-(specify) <u>Managed Care</u>	1,387,391	47
48	Other-(specify) <u>Respite</u>	250	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,341,523	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

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	1,753	1,761	\$ 95,511	\$ 54.24	1
2	Assistant Director of Nursing	672	672	29,066	43.25	2
3	Registered Nurses	19,261	23,078	902,292	39.10	3
4	Licensed Practical Nurses	1,531	1,769	62,335	35.24	4
5	CNAs & Orderlies	20,394	28,570	558,024	19.53	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	1,920	1,920	57,528	29.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,207	7,569	94,685	12.51	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,775	4,381	55,005	12.56	18
19	Laundry					19
20	Administrator	2,080	2,080	120,000	57.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,872	3,930	74,344	18.92	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) See Attached	1,817	1,885	71,639	38.00	33
34	TOTAL (lines 1 - 33)	64,282	77,615	\$ 2,120,429 *	\$ 27.32	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	143	\$ 7,842	01-03	35
36	Medical Director	Per Visit	339	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	2,818	10-03	38
39	Pharmacist Consultant	Monthly	1,883	10-03	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	12	808	12-03	45
46	Other(specify)				46
47	Rehab Consultant	Per Visit	300	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	155	\$ 13,990		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	261	\$ 16,983	10-03	50
51	Licensed Practical Nurses	897	38,533	10-03	51
52	Certified Nurse Assistants/Aides	2,829	99,021	10-03	52
53	TOTAL (lines 50 - 52)	3,988	\$ 154,537		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Sarah Pappe	Administrator	0	\$ 120,000	Workers' Compensation Insurance	\$	40,068	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance		19,943	Advertising: Employee Recruitment	58,647	
				FICA Taxes		162,213	Health Care Worker Background Check	1,545	
				Employee Health Insurance		33,086	(Indicate # of checks performed 155)		
				Employee Meals			Patient Background Checks	280 2,800	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	14,920	
				Awards and Gifts		961	Licenses & Fees	1,335	
				Employee Relations		3,059			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 120,000						
B. Administrative - Other									
Description			Amount						
Asbury Healthcare - Management Fees			\$ 272,413						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 272,413						
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	
ADP	Payroll Processing	\$	3,012			\$	Out-of-State Travel	\$	
Allscripts Healthcare	IT Management		4,500						
PointClickCare Technologies	Data Processing		29,662						
Waystar	Revenue Cycle Management		850				In-State Travel		
Early Sense	Resident Monitoring		61,613						
Ability Network	Revenue Cycle Management		800						
Consonus CoPilot	Data Processing		1,400						
Personnel Planners	Unemployment Tax Consult		300				Seminar Expense	349	
Karen Mandel	Design Consultant		750						
Asbury Healthcare	Consulting/Bookkeeping		154,534						
See Attached	Legal		21,257						
See Supplemental Schedule			13,002				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 291,680	TOTAL			\$	(agree to Sch. V, line 24, col. 8)	\$ 349

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- | | |
|--|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>No</u>
If YES, give association name and amount. <u>N/A</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>10 Years</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>18,841</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>89,968</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>
 c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% Ln 14</u>
 d. Have vehicle usage logs been maintained? <u>Yes</u>
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u>
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u>
 g. Does the facility transport residents to and from day training? <u>No</u>
 Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u> </p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u>
Firm Name: <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|--|--|