

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0050799 Facility Name: Astoria Place Living & Rehab Address: 6300 N. California Chicago 60659 County: Cook Telephone Number: (773) 973-1900 Fax #: (773) 973-1904 HFS ID Number: Date of Initial License for Current Owners: 01/01/10 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Amanda Springborn Telephone Number: (314) 925-3838 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) McGladrey LLP 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173 (Telephone) (847) 517-7070 Fax #: (847) 517-7067 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Astoria Place Living & Rehab# 0050799 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 bedsN/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>164</u>	Skilled (SNF)	<u>164</u>	<u>60,024</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>164</u>	TOTALS	<u>164</u>	<u>60,024</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>40,113</u>	<u>3,676</u>	<u>7,882</u>	<u>51,671</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>40,113</u>	<u>3,676</u>	<u>7,882</u>	<u>51,671</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.08%

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

None (Do not include bed-hold days in Section B.)

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

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

None

F. Does the facility maintain a daily midnight census?

YesG. 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 01/01/10

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 01/01/10NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 164 and days of care provided 7,344Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

	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	318,732	31,143	17,880	367,755		367,755		367,755			1
2	Food Purchase		372,114		372,114		372,114	23	372,137			2
3	Housekeeping	188,894	42,816		231,710		231,710	1,014	232,724			3
4	Laundry	62,082	22,955		85,037		85,037		85,037			4
5	Heat and Other Utilities			241,467	241,467		241,467	1,469	242,936			5
6	Maintenance	71,845		105,413	177,258		177,258	4,447	181,705			6
7	Other (specify):*											7
8	TOTAL General Services	641,553	469,028	364,760	1,475,341		1,475,341	6,953	1,482,294			8
	B. Health Care and Programs											
9	Medical Director			84,600	84,600		84,600		84,600			9
10	Nursing and Medical Records	3,016,971	203,011	90,706	3,310,688		3,310,688	27,545	3,338,233			10
10a	Therapy											10a
11	Activities	122,901	8,873	3,122	134,896		134,896		134,896			11
12	Social Services	109,577		5,959	115,536		115,536	2,197	117,733			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,249,448	211,884	184,387	3,645,719		3,645,719	29,742	3,675,461			16
	C. General Administration											
17	Administrative	246,230		688,077	934,307		934,307	(612,985)	321,322			17
18	Directors Fees											18
19	Professional Services			159,412	159,412		159,412	1,869	161,281			19
20	Dues, Fees, Subscriptions & Promotions			25,835	25,835		25,835	302	26,137			20
21	Clerical & General Office Expenses	118,015	(10,532)	293,837	401,320		401,320	131,355	532,675			21
22	Employee Benefits & Payroll Taxes			850,005	850,005		850,005		850,005			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,111	3,111		3,111	(1,112)	1,999			24
25	Other Admin. Staff Transportation			16,931	16,931		16,931		16,931			25
26	Insurance-Prop.Liab.Malpractice			122,442	122,442		122,442	644	123,086			26
27	Other (specify):* Mgmt Alloc of Ben-A							34,187	34,187			27
28	TOTAL General Administration	364,245	(10,532)	2,159,650	2,513,363		2,513,363	(445,741)	2,067,622			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,255,246	670,380	2,708,797	7,634,423		7,634,423	(409,046)	7,225,378			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			139,786	139,786		139,786	145,283	285,069			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,340	32,340		32,340	265,846	298,186			32
33	Real Estate Taxes			76,835	76,835		76,835	115,045	191,880			33
34	Rent-Facility & Grounds			1,017,312	1,017,312		1,017,312	(432,235)	585,077			34
35	Rent-Equipment & Vehicles			61,069	61,069		61,069	120	61,189			35
36	Other (specify):*											36
37	TOTAL Ownership			1,327,342	1,327,342		1,327,342	94,059	1,421,401			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,805	274,203	782,655	1,059,663		1,059,663		1,059,663			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			257,836	257,836		257,836		257,836			42
43	Other (specify):* Non-Allowable Co			529,840	529,840		529,840	(529,840)	(0)			43
44	TOTAL Special Cost Centers	2,805	274,203	1,570,331	1,847,339		1,847,339	(529,840)	1,317,499			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,258,051	944,583	5,606,470	10,809,104		10,809,104	(844,827)	9,964,277			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.)

		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	(24,293)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,488)	30		9
10	Interest and Other Investment Income	(276)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,720)	43		18
19	Entertainment				19
20	Contributions	(87,685)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	1,137	43		24
25	Fund Raising, Advertising and Promotional		43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax	(49,308)			26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(364,480)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (533,113)		\$	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)	(311,714)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (311,714)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (844,827)		37

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

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

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

Astoria Place Living & Rehab

Report Period Beginning:

Ending:

ID#0050799

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Medicaid Tax	\$ (90,036)	43	1
2	Lab & Radiology	(45,004)	43	2
3				3
4	Patient pers. Items	(851)	43	4
5	Admitting	(47,865)	43	5
6	Allowance for bad debts	(180,777)	43	6
7	Charity Discounts	(18,555)	43	7
8	Disallow Travel and Seminar	(1,296)	24	8
9	Adj Prior Year Exp	20,117	43	9
10	Non-allowable legal fees	(2,263)	19	10
11	Reclass Repairs & Maintenance	2,050	6	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	(364,480)		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
Chaim Rajchenbach	28	See Pg 6-Supp		See Pg6-Supp		
Menachem Shabat	28					
Ronald Shabat	14					
Shari Borenstein	5					
Jamie Dlatt	5					
Howard Borenstein	5					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒	X	YES	☐	NO
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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	2	Dietary	\$	Legacy Healthcare Financial Services, LLC	100.00%	\$ 23	\$ 23	1
2	V	3	Housekeeping Salaries		Legacy Healthcare Financial Services, LLC	100.00%	987	987	2
3	V	3	Housekeeping Supplies		Legacy Healthcare Financial Services, LLC	100.00%	27	27	3
4	V	5	Utilities		Legacy Healthcare Financial Services, LLC	100.00%	1,469	1,469	4
5	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services, LLC	100.00%	2,397	2,397	5
6	V	10	Nursing Salary		Legacy Healthcare Financial Services, LLC	100.00%	0		6
7	V	17	Administrative Salary - Mgmt Alloc	688,077	Legacy Healthcare Financial Services, LLC	100.00%	48,000	(640,077)	7
8	V	19	Other Professional Fees		Legacy Healthcare Financial Services, LLC	100.00%	2,198	2,198	8
9	V	19	Accounting		Legacy Healthcare Financial Services, LLC	100.00%			9
10	V	19	Legal Fees		Legacy Healthcare Financial Services, LLC	100.00%	1,438	1,438	10
11	V	19	Data Processing		Legacy Healthcare Financial Services, LLC	100.00%	1,983	1,983	11
12	V	20	Dues, Licenses, & Fees		Legacy Healthcare Financial Services, LLC	100.00%	52	52	12
13	V	21	Office Supplies		Legacy Healthcare Financial Services, LLC	100.00%	9,726	9,726	13
14	Total			\$ 688,077			\$ 68,300	\$ * (619,777)	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	21	Clerical Salaries	\$	Legacy Healthcare Financial Services, LLC	100.00%	\$ 121,368	\$ 121,368	15
16	V	24	Travel		Legacy Healthcare Financial Services, LLC	100.00%	184	184	16
17	V	25	Education & Seminars		Legacy Healthcare Financial Services, LLC	100.00%	0		17
18	V	26	Insurance Expense		Legacy Healthcare Financial Services, LLC	100.00%	644	644	18
19	V	27	Employee Benefits - Mgmt Alloc		Legacy Healthcare Financial Services, LLC	100.00%	32,749	32,749	19
20	V	30	Depreciation Expense		Legacy Healthcare Financial Services, LLC	100.00%	1,046	1,046	20
21	V	32	Interest Expense		Legacy Healthcare Financial Services, LLC	100.00%	4	4	21
22	V	33	Real Estate Taxes		Legacy Healthcare Financial Services, LLC	100.00%	0		22
23	V	34	Rent Expense		Legacy Healthcare Financial Services, LLC	100.00%	11,186	11,186	23
24	V	35	Equipment Rental		Legacy Healthcare Financial Services, LLC	100.00%	0		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			\$			\$ 167,181	\$ * 167,181	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	6	Repairs & Maintenance	\$	Legacy Real Properties, LLC	100.00%	\$	\$	15
16	V	21	Office Expense		Legacy Real Properties, LLC	100.00%			16
17	V	30	Depreciation		Legacy Real Properties, LLC	100.00%	2,104	2,104	17
18	V	32	Interest		Legacy Real Properties, LLC	100.00%	3,813	3,813	18
19	V	33	Real Estate Taxes		Legacy Real Properties, LLC	100.00%	3,710	3,710	19
20	V	34	Rent		Legacy Real Properties, LLC	100.00%			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			\$			\$ 9,627	\$ * 9,627	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.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		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	10	RN Salary	\$	Progressive Healthcare Consulting	100.00%	\$ 10,620	\$ 10,620	15
16	V	12	Clergy Salary		Progressive Healthcare Consulting	100.00%	2,197	2,197	16
17	V	17	Administrator		Progressive Healthcare Consulting	100.00%	22,406	22,406	17
18	V	19	Professional Fees		Progressive Healthcare Consulting	100.00%	146	146	18
19	V	20	Fees and Subscriptions		Progressive Healthcare Consulting	100.00%			19
20	V	21	Clerical & General		Progressive Healthcare Consulting	100.00%	248	248	20
21	V	15	Emp. Ben - Nursing		Progressive Healthcare Consulting	100.00%	1,438	1,438	21
22	V	35	Auto Lease		Progressive Healthcare Consulting	100.00%	120	120	22
23	V	17	Administrator		Progressive Healthcare Consulting	100.00%	4,686	4,686	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			\$			\$ 41,861	\$ * 41,861	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.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		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	\$	Astoria Real Properties, LLC	100.00%	\$ 11,733	\$ 11,733	15
16	V	19	Legal Fees		Astoria Real Properties, LLC	100.00%	3,558	3,558	16
17	V	20	Dues and Subscriptions		Astoria Real Properties, LLC	100.00%	250	250	17
18	V	21	Bank Service Charge		Astoria Real Properties, LLC	100.00%	13	13	18
19	V	30	Depreciation		Astoria Real Properties, LLC	100.00%	143,621	143,621	19
20	V	32	Interest	2,187	Astoria Real Properties, LLC	100.00%	258,502	256,315	20
21	V	32	Loan Fees		Astoria Real Properties, LLC	100.00%	5,990	5,990	21
22	V	33	Real Estate Tax		Astoria Real Properties, LLC	100.00%	111,335	111,335	22
23	V	34	Rent Expense	443,421	Astoria Real Properties, LLC	100.00%		(443,421)	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			\$ 445,608			\$ 535,002	\$ * 89,394	39

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

Facility Name & ID Number

Astoria Place Living & Rehab

0050799

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	Chaim Rajchenbach		Grove Lincoln Park Living & Rehab Ctr.	Chicago	Legacy Healthcare	Skokie	Management Co.	1
2	Menachem Shabat		Pine Acres Rehab & Living Center	Dekalb	Financial Svcs, LLC			2
3	Jack Rajchenbach		Astoria Place Living & Rehab	Chicago				3
4	Ronald Shabat		The Grove of Evanston	Evanston	Legacy Real	Skokie	Real Estate	4
5	Menachem Berger		Grove At Skokie Living & Rehab Center	Chicago	Properties, LLC			5
6	Jake Weiss		Elmbrook Nursing	Elmbrook				6
7	The Rajchenbach Family Trust		The Grove of LaGrange Park	LaGrange Park	Grove Healthcare	Skokie	Real Estate	7
8	The Robert Hartman Family Trust		Lakefront Nursing & Rehab Center	Chicago	Properties, LLC			8
9			Bridgeview Health Care Center	Bridgeview				9
10			The Carlton at the Lake	Chicago	Shabat &	Chicago	Management Co.	10
11			Clark Manor Convalescent Center	Chicago	Associates, LLC			11
12			Springfield Terrace	Springfield				12
13			Tower Hill Healthcare Center	South Elgin	JLR Management	Chicago	Management Co.	13
14			Glenview Terrace Nursing Center	Glenview				14
15			The Imperial Grove Pavilion	Chicago				15
16			The Arc of Jacksonville, Ltd.	Jacksonville				16
17			Peterson Park Health Care Center	Chicago				17
18			Embassy Health Care Center	Wilmington				18
19			Whitehall North	Deerfield				19
20			Harmony Nursing & Rehab Center	Chicago				20
21			Florence Nursing Home	Marengo				21
22			The Fountain's	Marion				22
23			Friendship Care Center - Herrin	Herrin				23
24			City Care Center of Cobden	Combden				24
25			Ridgeway Manor	Ridgeway				25
26			Sheridan Health Care Center	Zion				26
27			Oak Grove Rehab & Skilled Care	Carbondale				27
28								28
29								29
30								30

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	Chaim Rajchenbach	Owner	Administrative	29.00	See Attached	See Att.	See Att.	Mgmt. Salary	\$ 24,000	17(7)	1
2	Menachem Shabat	Owner	Administrative	29.00	See Attached	See Att.	See Att.	Mgmt. Salary	24,000	17(7)	2
3	Jamie Dlatt	Owner	Administrative	5.00	See Attached	See Att.	See Att.	Salary	95,635	17(1)	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 143,635		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 Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Legacy Healthcare Financial Services, LLC
Street Address 7040 North Ridgeway Avenue
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 679-9797
Fax Number (847) 679-3676

	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	2	Dietary	Patient Days	716,018	13	\$ 270	\$	60,024	\$ 23	1
2	3	Housekeeping Salaries	Patient Days	716,018	13	11,779	11,779	60,024	987	2
3	3	Housekeeping Supplies	Patient Days	716,018	13	318		60,024	27	3
4	5	Utilities	Patient Days	716,018	13	17,526		60,024	1,469	4
5	6	Repairs & Maintenance	Patient Days	716,018	13	28,596		60,024	2,397	5
6	10	Nursing Salary	Patient Days	716,018	13			60,024	0	6
7	17	Administrative Salary - Mgmt All	Hours	100	12	400,000	400,000	12	48,000	7
8	19	Other Professional Fees	Patient Days	716,018	13	26,219		60,024	2,198	8
9	19	Legal Fees	Patient Days	716,018	13	17,158		60,024	1,438	9
10	19	Data Processing	Patient Days	716,018	13	23,653		60,024	1,983	10
11	20	Dues, Licenses, & Fees	Patient Days	716,018	13	625		60,024	52	11
12	21	Office Supplies	Patient Days	716,018	13	116,015		60,024	9,726	12
13	21	Clerical Salaries	Patient Days	716,018	13	1,447,779	1,447,779	60,024	121,368	13
14	24	Travel	Patient Days	716,018	13	2,200		60,024	184	14
15	25	Education & Seminars	Patient Days	716,018	13			60,024	0	15
16	26	Insurance Expense	Patient Days	716,018	13	7,687		60,024	644	16
17	27	Employee Benefits - Mgmt Alloc	Patient Days	716,018	13	228,907		60,024	19,189	17
18	27	Employee Benefits - Mgmt Alloc	Patient Days	100	12	113,000		12	13,560	18
19	30	Depreciation Expense	Bed Days Available	716,018	13	12,480		60,024	1,046	19
20	32	Amortization Expense	Patient Days	716,018	13	51		60,024	4	20
21	33	Real Estate Taxes	Patient Days	716,018	13			60,024	0	21
22	34	Rent Expense	Patient Days	716,018	13	133,442		60,024	11,186	22
23										23
24										24
25	TOTALS					\$ 2,587,705	\$ 1,859,558		\$ 235,481	25

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Progressive Healthcare Consulting
Street Address 7040 North Ridgeway Avenue
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847) 679-9797
Fax Number (847) 679-3676

	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	10	RN Salary	Patient Days	498,858	10	\$ 88,262	\$ 88,262	60,024	\$ 10,620	1
2	12	Clergy Salary	Patient Days	498,858	10	18,263	18,263	60,024	2,197	2
3	17	Administrator	Patient Days	498,858	10	186,212	186,212	60,024	22,406	3
4	19	Professional Fees	Patient Days	498,858	10	1,215		60,024	146	4
5	20	Fees and Subscriptions	Patient Days	498,858	10			60,024		5
6	21	Clerical & General	Patient Days	498,858	10	2,058		60,024	248	6
7	15	Emp. Ben - Nursing	Patient Days	498,858	10	11,955		60,024	1,438	7
8	35	Auto Lease	Patient Days	498,858	10	999		60,024	120	8
9	17	Administrator	Hours Worked	40	9	38,969	38,969	5	4,686	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					\$ 347,933	\$ 331,706		\$ 41,861	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	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	The Private Bank		X	Back up CD	\$1,008.33	03/03/10	\$ 500,000	\$ 500,000	02/02/11	0.0220	\$ 14,938	1	
2	The Private Bank		X	Mortgage		8/30/12	12,600,000	12,600,000		Varies	243,564	2	
3												3	
4												4	
5												5	
	Working Capital												
6	The Private Bank		X	Line of Credit	\$1,418.96	03/03/10		320,000		0.0600	32,340	6	
7												7	
8												8	
9	TOTAL Facility Related				\$2,427.29		\$ 13,100,000	\$ 13,420,000			\$ 290,842	9	
	B. Non-Facility Related*												
10								Allocation from management			9,807	10	
11								Interest income offset			(2,463)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 7,344	14	
15	TOTALS (line 9+line14)						\$ 13,100,000	\$ 13,420,000			\$ 298,186	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 2011 report.			\$	<u>183,000</u>	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.)		2011	\$	<u>259,835</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>76,835</u>	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>111,335</u>	4
		Allocated from LRP		<u>3,710</u>	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<u>191,880</u>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007		<u>8</u>	
		2008		<u>9</u>	
		2009		<u>10</u>	
		2010	<u>146,865</u>	<u>11</u>	
		2011	<u>259,835</u>	<u>12</u>	
<u>Accrual based on unpaid 2012 taxes due in 2013</u>					
<u>Real estate taxes for FY 12 include \$176,748 paid in 2011 and \$83,087 in 2012</u>					
		13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Astoria Place Living & Rehab

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0050799

CONTACT PERSON REGARDING THIS REPORT
Michael Navarro

TELEPHONE
(847) 679-9797
FAX #:
(773) 973-1904

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	13-01-107-030-0000	2818 W Devon Avenue	\$ 176,747.73	\$ 176,747.73
2.	10-35-104-076-0000	7040 Ridgeway Avenue	\$ 42,154.05	\$ 3,710.00
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 218,901.78	\$ 180,457.73

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 50,536

B. General Construction Type: Exterior Brick Frame Wood

Number of Stories 4

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).

N/A

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 use		2012	\$ 559,576	1
2	Allocated from Legacy Real Properties			6,858	2
3	TOTALS			\$ 566,434	3

Facility Name & ID Number Astoria Place Living & Rehab

0050799

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		Allocation of Purchase Price	2012	1974	\$ 10,156,976	\$	40	\$ 84,999	\$ 84,999	\$ 84,999	4
5		Allocated from Legacy Real Properties			53,137			2,104	2,104	6,199	5
6											6
7											7
8											8
	Improvement Type**										
9		Door System and Locks		2010	6,590		10	659	659	1,646	9
10		Roofing		2010	10,125		10	1,013	1,013	2,531	10
11		Landscape Irrigation System		2010	6,500		10	650	650	1,625	11
12		Resident Room Built-in Furniture		2010	84,920		15	5,661	5,661	14,154	12
13		Office Furniture		2010	6,071		15	405	405	1,011	13
14		Carpeting		2010	15,513		5	3,103	3,103	7,756	14
15		Fire Alarm System		2010	19,877		10	1,988	1,988	4,970	15
16		Electrical		2010	17,930		20	896	896	2,240	16
17		Admin Bathroom		2010	8,450		20	422	422	1,055	17
18		Millwork		2010	59,488		15	3,966	3,966	9,915	18
19		Painting and drywall		2010	16,878		5	3,376	3,376	8,440	19
20		Waterfountain		2010	1,275		10	128	128	320	20
21		Improvements		2010	26,520		20	1,326	1,326	3,315	21
22		Therapy Room Remodel		2010	10,375		20	519	519	1,296	22
23		Plumbing		2010	23,585		20	1,179	1,179	2,949	23
24		Tile and Installation		2010	40,616		10	4,062	4,062	10,155	24
25		Grease Trap		2010	14,150		10	1,415	1,415	3,539	25
26		Phone System		2010	7,000		10	700	700	1,750	26
27		Elevator		2010	3,874		20	194	194	485	27
28		Windows		2010	209,850		20	10,493	10,493	26,231	28
29		1st Floor Rehab		2010	111,411		20	5,571	5,571	13,926	29
30		Satellite		2010	12,500		10	1,250	1,250	3,125	30
31		PT Room		2010	13,247		10	1,325	1,325	3,311	31
32		Window Drapes		2010	31,707		5	6,341	6,341	15,854	32
33		Resident Room & Rehab		2010	56,575		20	2,828	2,828	7,070	33
34		Electronic		2010	16,265		20	813	813	2,034	34
35		Family Dining		2010	7,000		20	350	350	875	35
36		Rehab Bathrooms		2010	7,808		10	781	781	1,951	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 Astoria Place Living & Rehab

0050799

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Wall covering	2010	\$ 14,943	\$	5	\$ 2,988	\$ 2,988	\$ 7,470	37
38	Signs	2010	24,203		10	2,420	2,420	6,050	38
39	Light Fixtures	2010	7,475		10	748	748	1,870	39
40	Window Guards	2010	3,800		20	190	190	475	40
41	New Fence	2010	23,922		15	1,595	1,595	3,986	41
42	Library	2010	36,204		20	1,810	1,810	4,525	42
43	Tuckpointing	2010	7,315		20	365	365	914	43
44	Architectural Design	2010	1,237		10	123	123	309	44
45	Nurses Station	2010	14,000		15	933	933	2,334	45
46	New Fire Pump	2010	4,236		20	212	212	530	46
47	Entrance Rehab (doors, automatic entrance, sconces and tile)	2010	37,684		10	3,768	3,768	9,420	47
48	2nd Floor Rehab (hand rails, carpeting)	2010	17,171		20	858	858	2,145	48
49	Parking Lot	2010	5,491		10	549	549	1,374	49
50	Landscaping	2010	28,850		10	2,885	2,885	7,214	50
51	Fire Pump Repairs	2011	2,965		20	148	148	222	51
52	2nd Floor Corridor Rehab	2011	24,879		20	1,244	1,244	1,866	52
53	2 New Elevators	2011	6,781		20	339	339	509	53
54	Plumbing Maintenance	2011	3,590		20	180	180	270	54
55	Dayroom - Roller Shades, Dining Room - Table Cloths	2011	4,281		5	856	856	1,284	55
56	Handrail End Caps, Rollershades, Elevator Floor (Removed Old, I	2011	10,790		5	2,158	2,158	3,237	56
57	Location and Room Signs	2011	5,927		10	593	593	889	57
58	Location and Room Signs	2011	6,082		10	608	608	912	58
59	Rehab Room Renovation	2011	10,000		20	500	500	750	59
60	Back-Up Generator Upkeep	2011	3,100		20	155	155	233	60
61	Rehab Room Renovation (#2)	2011	19,350		20	968	968	1,452	61
62	Rehab Room Renovation (#3)	2011	9,400		20	470	470	705	62
63	Elevator Maintenance	2011	2,930		20	147	147	220	63
64									64
65	Sprinkler upgrade	2012	10,888		20	272	272	272	65
66	Railing bars for existing stairways	2012	6,900		20	173	173	173	66
67	Relocate doors	2012	3,530		20	88	88	88	67
68	Fire dampers	2012	22,351		20	559	559	559	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,436,487	\$		\$ 177,418	\$ 177,418	\$ 306,983	70

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

XI. OWNERSHIP COSTS (continued)

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

1 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		\$ 11,436,487	\$		\$ 177,418	\$ 177,418	\$ 306,983	1
2	Electrical work	2012	5,709		20	143	143	143	2
3	Sign	2012	11,547		10	577	577	577	3
4	Electrical	2012	5,270		20	132	132	132	4
5	Design fees	2012	4,781		5	478	478	478	5
6									6
7									7
8	Book depreciation			89,949			(89,949)		8
9									9
10	Allocated from Legacy Real Properties	2009	30,176			244	244	4,149	10
11	Allocated from Legacy Real Properties	2010	9,176			74	74	918	11
12	Allocated from Legacy Real Properties	2011	13,042			105	105	1,304	12
13	Allocated from Legacy Real Properties								13
14	Allocated from Legacy Healthcare Financial Services	2012	2,390			182	182	120	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,518,579	\$ 89,949		\$ 179,353	\$ 89,404	\$ 314,804	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	\$ 194,601	\$ 39,511	\$ 38,491	\$ (1,020)	3-7 yrs	\$ 93,111	71
72	Current Year Purchases	949,776	10,326	65,666	55,340	5 yrs	65,666	72
73	Fully Depreciated Assets							73
74	See Schedule 13A	18,378		1,559	1,559	7	4,798	74
75	TOTALS	\$ 1,162,755	\$ 49,837	\$ 105,716	\$ 55,879		\$ 163,575	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	2	
	Reference	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)	\$ 13,247,768	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 139,786	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 285,069	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 145,283	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 478,379	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.

Schedule 13A

Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
1 Allocation from LHFS, Inc	4,541		864		7	966
2 Allocated from Legacy Real Properties	13,837		695		7	3,832
Totals	18,378	-	1,559	-		4,798

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:	1974	164	01/01/2011	\$ 573,891			3
4	Additions							4
5								5
6	Allocated from Legacy Real Properties, LLC				11,186			6
7	TOTAL		164		\$ 585,077			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: \$ 61,069
- Description: Bed Rental: \$60,285; Postage Machine \$784
- (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	Allocation from Progressive		\$	\$ 120	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 120	21

10. Effective dates of current rental agreement:

Beginning 12/31/2009

Ending 12/31/2013

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	\$ 867,970
13.	/2014	\$ 957,760
14.	/2015	\$

* 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

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

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.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	3,718	\$ 267,721	\$	3,718	\$ 267,721	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,435	103,284		1,435	103,284	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,717	411,650		5,717	411,650	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				274,203		274,203	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>		94	2,805				94	2,805	12
13	Other (specify): _____									13
14	TOTAL			\$ 2,805	10,870	\$ 782,655	\$ 274,203	10,964	\$ 1,059,663	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>328,191</u>)	3,286,803	3,286,803	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	133,223	133,223	6
7	Other Prepaid Expenses	94,126	141,868	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch17A</u>	177,297	177,297	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,691,449	\$ 3,739,191	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		566,434	13
14	Buildings, at Historical Cost		10,210,113	14
15	Leasehold Improvements, at Historical Cost	1,249,262	1,308,466	15
16	Equipment, at Historical Cost	286,555	1,162,755	16
17	Accumulated Depreciation (book methods)	(321,505)	(478,379)	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)	\$ 1,214,312	\$ 12,769,389	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,905,761	\$ 16,508,580	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 831,396	\$ 670,052	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	481,246	481,246	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		111,335	32
33	Accrued Interest Payable		52,500	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch17A</u>	288,555	(146,476)	36
37	<u>See Sch17A</u>	2,189,751	2,189,751	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,790,948	\$ 3,358,408	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	320,000	820,000	39
40	Mortgage Payable		12,600,000	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)	\$ 320,000	\$ 13,420,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,110,948	\$ 16,778,408	46
47	TOTAL EQUITY (page 18, line 24)	\$ 794,813	\$ (269,828)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,905,761	\$ 16,508,580	48

*(See instructions.)

Schedule 17A

	<u>Operating</u>	<u>After Consolidation</u>
Line 9		
Security Deposits	2,587	2,587
Due to Medicare	139,981	139,981
IL B L F	44,526	44,526
State Unemp Tax	(12,608)	(12,608)
Due to Others	1,562	1,562
Due T/F Leg Charity	1,249	1,249
Total to L 9	<u>177,297</u>	<u>177,297</u>

Line 36		
Trust Clearing Account	7,770	7,770
Refund-Transfer	14,145	14,145
State Assessment Fee	69,222	69,222
Accrued Management Fee	155,730	155,730
Federal UC Tax	(1,756)	(1,756)
Accrued FICA	25,589	25,589
FICA Withheld	10,411	10,411
Federal Withhold Tax	15,430	15,430
Due To/From LP	995	995
Due To/From Related	(10,187)	(445,218)
Due To/From GHCP	1,206	1,206
Total to L 36	<u>288,555</u>	<u>(146,476)</u>

Line 37		
AHCP	435,031	435,031
HDSI Retainer	1,754,720	1,754,720
Total to L 37	<u>2,189,751</u>	<u>2,189,751</u>

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,173,919	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(1,348,919)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (175,000)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	969,813	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)	\$ 969,813	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)	\$ 794,813	24 *

* This must agree with page 17, line 47.

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		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,908,489	1
2	Discounts and Allowances for all Levels	(103,482)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,805,007	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,702,850	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,702,850	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	243,546	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	27,790	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 271,336	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(276)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (276)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,778,917	30

2		3	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,475,341	31
32	Health Care	3,645,719	32
33	General Administration	2,513,363	33
B. Capital Expense			
34	Ownership	1,327,342	34
C. Ancillary Expense			
35	Special Cost Centers	1,589,503	35
36	Provider Participation Fee	257,836	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,809,104	40
41	Income before Income Taxes (line 30 minus line 40)**	969,813	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 969,813	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,405,587	44
45	Private Pay - Net Inpatient Revenue	1,105,476	45
46	Medicare - Net Inpatient Revenue	2,293,944	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,805,007	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.
^ - LLC members are cash basis tax payers.

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	2,164	2,207	\$ 104,253	\$ 47.24	1
2	Assistant Director of Nursing	1,643	1,677	66,850	39.86	2
3	Registered Nurses	27,651	31,568	942,221	29.85	3
4	Licensed Practical Nurses	26,744	27,923	705,853	25.28	4
5	CNAs & Orderlies	82,920	90,099	1,029,112	11.42	5
6	CNA Trainees					6
7	Licensed Therapist	94	94	2,805	29.84	7
8	Rehab/Therapy Aides	6,607	7,427	119,135	16.04	8
9	Activity Director	1,850	1,971	30,756	15.60	9
10	Activity Assistants	5,997	6,382	92,145	14.44	10
11	Social Service Workers	4,928	5,169	109,577	21.20	11
12	Dietician					12
13	Food Service Supervisor	6,629	6,913	66,480	9.62	13
14	Head Cook	1,893	2,155	29,063	13.49	14
15	Cook Helpers/Assistants	19,071	20,524	223,189	10.87	15
16	Dishwashers					16
17	Maintenance Workers	4,215	4,520	71,845	15.89	17
18	Housekeepers	16,052	17,444	188,894	10.83	18
19	Laundry	4,824	5,235	62,082	11.86	19
20	Administrator	3,992	4,126	182,894	44.33	20
21	Assistant Administrator	2,381	2,523	63,336	25.10	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,802	11,187	118,014	10.55	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	2,633	2,796	49,547	17.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	233,090	251,940	\$ 4,258,051 *	\$ 16.90	34

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	374	\$ 17,880	1(3)	35
36	Medical Director	Monthly	84,600	9(3)	36
37	Medical Records Consultant	8	4,512		37
38	Nurse Consultant	1,170	27,000	10(3)	38
39	Pharmacist Consultant	Monthly	9,250	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,122	11(3)	44
45	Social Service Consultant	94	5,959	12(3)	45
46	Other(specify) <u>Purchasing Consular</u>	154	16,925	10(7)	46
47	<u>MDS Consultant</u>	Monthly	48,000	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	1,800	\$ 217,248		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	63	1,944	10(3)	52
53	TOTAL (lines 50 - 52)	63	\$ 1,944		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries	D. Employee Benefits and Payroll Taxes	F. Dues, Fees, Subscriptions and Promotions
Name Function Ownership % Amount	Description Description Amount	Description Amount
Mordechai Polstein Administrator 0 \$ 16,345	Workers' Compensation Insurance \$ 143,378	IDPH License Fee \$ 455
Jamie Dlatt Administrator 5 95,635	Unemployment Compensation Insurance 135,760	Advertising: Employee Recruitment 100
John Marc Siangchio Administrator 0 79,731	FICA Taxes 326,955	Health Care Worker Background Check (Indicate # of checks performed 400) 4,805
Aaron Cohen Asst. Admin 0 49,657	Employee Health Insurance 188,840	Patient Background Checks 341 4,090
Yair Zuckerman Asst. Admin 0 4,862	Employee Meals	Miscellaneous Licenses & Fees 395
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) \$ 246,230	Illinois Municipal Retirement Fund (IMRF)*	IL Council on Long Term Care Dues 15,990
B. Administrative - Other Description Amount Management Fees \$ 688,077 Eliminated on Sch V Col 7 TOTAL (agree to Schedule V, line 22, col.8) \$ 850,005 E. Schedule of Non-Cash Compensation Paid to Owners or Employees Description Line # Amount N/A In-State Travel Seminar Expense 1,815 Allocation from Legacy Healthcare 184 Entertainment Expense (TOTAL (agree to Sch. V, line 24, col. 8)) \$ 1,999	G. Schedule of Travel and Seminar** Description Amount Out-of-State Travel \$ In-State Travel Seminar Expense 1,815 Allocation from Legacy Healthcare 184 Entertainment Expense (TOTAL (agree to Sch. V, line 24, col. 8)) \$ 1,999	C. Professional Services Vendor/Payee Type Amount E Health Data Solutions Data Processing \$ 1,477 Health Data System, Inc Data Processing 11,418 Comcast Cable Data Processing 1,282 LTC Solutions Data Processing 3,200 Ivans Inc. Data Processing 214 Singer Networks LLC. Data Processing 8,272 American Express Data Processing 3,406 Tiktek IT Solutions Data Processing 1,825 McGladrey LLP Accounting Fees 29,869 Frost Ruttenberg & Rothblatt PC Accounting Fees 1,044 Legacy FR&R Accounting Fees 1,275 See Sch 21C Various 96,130 TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.) \$ 159,412

*** Attach copy of IMRF notifications**

****See instructions.**

Schedule 21C - Other Professional Fees

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
Meyer Magence	Legal	5,375
Skidelsky & Associates	Legal	185
Stone McGuire & Siegal	Legal	6,116
Much Shelist	Legal	2,749
Sheryl E Fuhr & Associates	Legal	5,013
Polsinelli Shughart PC	Legal	1,132
Scott & Krause	Legal	3,440
Ashman & Stein	Legal	1,131
Korey Cotter Heather & Richardso	Legal	10,038
Sandra L. Thiel	Legal	2,725
Legacy Reimb Expenses	Legal	3,455
December 2012 Accruals	Legal	5,908
SAS Architects & Planners	Architecture Services	1,226
Rabbi Mel Lifscics	Religious	7,000
ITT Source tech	Dietary	1,095
Pioneer	Data Processing	2,150
Patrick M Gzehoviak	Data Processing	276
Personnel Planners	Unemployment consultant	1,756
Record payment to A. Ojomo	JE	600
Paymed LLC	Medicare B Billing	7,316
Petty Cash	Petty cash	76
Singer Networks	IT Support	2,450
Legacy HC Reim Expenses	JE	651
ML Enterprises	Purchasing	4,550
Collaborative Healthcare	Purchasing	175
Internal Medicine Affiliates	Medical Services	4,400
Alex Orthopedics LLC	Medical Services	2,000
Journal Entrys	Data Processing	5,800
Journal Entrys	Data Processing	7,342
To page 21C		<u>96,130</u>
Total per P3 L19 C3		<u>159,412</u>

Less: Non-Allowable Legal	(2,263)
Legacy Healthcare Allocation	5,619
Astoria Real Property Allocation	15,291
Progressive Healthcare Allocation	146
Medical Consultant Reclass	<u>(16,925)</u>
Agrees w/ P3 L19 C8	<u><u>161,281</u></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	Amount of Expense Amortized Per Year								
					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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

ILCLTC: \$15,990

(3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

49,911

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.

\$

257,836

This amount is to be recorded on line 42 of Schedule V.

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

0

Has any meal income been offset against related costs?

No

Indicate the amount.

\$

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?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A

(17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

(18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.