

		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>0053900</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Astoria Place Living Rehab</u>		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.	
Address: <u>6300 N California Av</u> <u>Chicago</u> <u>60659</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>			
Telephone Number: <u>(773) 973-1900</u> Fax # <u>(773) 973-1904</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>1/1/2010</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ INDIVIDUAL	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ CORPORATION	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
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: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		Paid Preparer	
		(Signed) _____ <u>04/29/2021</u>	
		* Subject to the attached Accountants' Consulting Report (Date)	
		(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u>	
		(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	
		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Astoria Place Living Rehab

0053900 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>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	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>38,377</u>	<u>2,435</u>	<u>6,316</u>	<u>47,128</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>38,377</u>	<u>2,435</u>	<u>6,316</u>	<u>47,128</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 78.52%

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 1/1/2010

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 1/1/2010 NO ☐

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 5,073

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Astoria Place Living Rehab # 0053900 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary		4,735	1,165,638	1,170,373		1,170,373	3,095	1,173,468			1
2	Food Purchase		2,194		2,194		2,194	5,888	8,082			2
3	Housekeeping		5,732	546,752	552,484		552,484	2,007	554,491			3
4	Laundry	109,946	22,422		132,368		132,368	136	132,504			4
5	Heat and Other Utilities			288,896	288,896		288,896	(12,078)	276,818			5
6	Maintenance	95,306	21,470	167,280	284,056		284,056	12,824	296,880			6
7	Other (specify):*											7
8	TOTAL General Services	205,252	56,553	2,168,566	2,430,371		2,430,371	11,873	2,442,244			8
	B. Health Care and Programs											
9	Medical Director			22,000	22,000		22,000		22,000			9
10	Nursing and Medical Records	3,947,736	204,644	48,920	4,201,300		4,201,300	99,635	4,300,935			10
10a	Therapy	272,542			272,542		272,542		272,542			10a
11	Activities	143,850	7,929	1,267	153,046		153,046	8	153,054			11
12	Social Services	236,808		4,306	241,114		241,114	5,377	246,491			12
13	CNA Training											13
14	Program Transportation			19,690	19,690		19,690		19,690			14
15	Other (specify):*							5,577	5,577			15
16	TOTAL Health Care and Programs	4,600,936	212,573	96,183	4,909,692		4,909,692	110,598	5,020,290			16
	C. General Administration											
17	Administrative	176,713			176,713		176,713	59,857	236,570			17
18	Directors Fees											18
19	Professional Services			352,010	352,010	(759)	351,251	(233,805)	117,446			19
20	Dues, Fees, Subscriptions & Promotions			75,526	75,526		75,526	(35,157)	40,369			20
21	Clerical & General Office Expenses	250,674	2,101	521,667	774,442		774,442	(132,748)	641,694			21
22	Employee Benefits & Payroll Taxes			801,536	801,536		801,536		801,536			22
23	Inservice Training & Education											23
24	Travel and Seminar			917	917		917	134	1,051			24
25	Other Admin. Staff Transportation			862	862		862	4,475	5,337			25
26	Insurance-Prop.Liab.Malpractice			313,108	313,108		313,108	17,981	331,089			26
27	Other (specify):*							23,991	23,991			27
28	TOTAL General Administration	427,387	2,101	2,065,626	2,495,114	(759)	2,494,355	(295,273)	2,199,082			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,233,575	271,227	4,330,375	9,835,177	(759)	9,834,418	(172,802)	9,661,616			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							548,113	548,113			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,800	12,800		12,800	887,790	900,590			32
33	Real Estate Taxes					759	759	336,847	337,606			33
34	Rent-Facility & Grounds			2,115,600	2,115,600		2,115,600	(2,105,907)	9,693			34
35	Rent-Equipment & Vehicles			23,086	23,086		23,086	4,347	27,433			35
36	Other (specify):*							127,064	127,064			36
37	TOTAL Ownership			2,151,486	2,151,486	759	2,152,245	(201,746)	1,950,499			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		373,082	736,710	1,109,792		1,109,792	(10,647)	1,099,145			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			360,661	360,661		360,661		360,661			42
43	Other (specify):*			653,652	653,652		653,652	(653,652)				43
44	TOTAL Special Cost Centers		373,082	1,751,023	2,124,105		2,124,105	(664,299)	1,459,806			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,233,575	644,309	8,232,884	14,110,768		14,110,768	(1,038,847)	13,071,921			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	(13,125)	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	114,548	30		9
10	Interest and Other Investment Income	(13,846)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	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	(620)	21		18
19	Entertainment	(735)	21		19
20	Contributions	(13,952)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(290,434)	21		24
25	Fund Raising, Advertising and Promotional	(6,392)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,035,393)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,259,950)		\$	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)	221,103		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 221,103		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,038,847)		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	Rebates	\$ (2,465)	21	1
2	Patient Personal Items	(587)	10	2
3	Bank Charges	(64,457)	21	3
4	Sequestration	(33,371)	21	4
5	Prior Period Dues	(519)	20	5
6	Additional R&M	5,760	06	6
7	Capitalized R&M	(3,175)	06	7
8	Bldg Co - Accounting	(9,571)	19	8
9	Bldg Co - Legal	(1,700)	19	9
10	Bldg Co - Amortization	(5,404)	36	10
11	Bldg Co - Filing Fees	(370)	20	11
12	Non Allowable Expense	(653,652)	43	12
13	Non Allowable Legal	(248,199)	19	13
14	Marketing License	(1,029)	20	14
15	PAC Dues	(16,621)	20	15
16	Swag Store	(33)	21	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	(1,035,393)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Astoria Place Living Rehab # 0053900 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			3,095									3,095	1
2	Food Purchase	(1)		5,889									5,888	2
3	Housekeeping			2,007									2,007	3
4	Laundry			136									136	4
5	Heat and Other Utilities	(13,125)				1,047							(12,078)	5
6	Maintenance	2,585		10,063		1,014		(838)					12,824	6
7	Other (specify):*													7
8	TOTAL General Services	(10,541)		21,191		2,061		(838)					11,873	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(587)		102,935					(2,713)				99,635	10
10a	Therapy													10a
11	Activities			8									8	11
12	Social Services			5,377									5,377	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				5,577								5,577	15
16	TOTAL Health Care and Programs	(587)		108,320	5,577				(2,713)				110,598	16
	C. General Administration													
17	Administrative			59,857									59,857	17
18	Directors Fees													18
19	Professional Services	(259,470)	11,271	19,651		441	(5,697)						(233,805)	19
20	Fees, Subscriptions & Promotions	(38,883)	370	3,355		1							(35,157)	20
21	Clerical & General Office Expenses	(392,115)		259,123		243							(132,748)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			134									134	24
25	Other Admin. Staff Transportation			4,475									4,475	25
26	Insurance-Prop.Liab.Malpractice		17,600	118		263							17,981	26
27	Other (specify):*			23,991									23,991	27
28	TOTAL General Administration	(690,468)	29,241	370,704		947	(5,697)						(295,273)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(701,596)	29,241	500,215	5,577	3,009	(5,697)	(838)	(2,713)				(172,802)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Astoria Place Living Rehab # 0053900 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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	114,548	427,108			6,457							548,113	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,846)	898,007			3,629							887,790	32
33	Real Estate Taxes		333,550			3,297							336,847	33
34	Rent-Facility & Grounds		(2,106,000)	30,386		(30,293)							(2,105,907)	34
35	Rent-Equipment & Vehicles				4,347								4,347	35
36	Other (specify):*	(5,404)	132,468										127,064	36
37	TOTAL Ownership	95,298	(314,867)	30,386	4,347	(16,910)							(201,746)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(10,647)			(10,647)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(653,652)											(653,652)	43
44	TOTAL Special Cost Centers	(653,652)								(10,647)			(664,299)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,259,950)	(285,626)	530,602	9,924	(13,901)	(5,697)	(838)	(2,713)	(10,647)			(1,038,847)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 2,106,000	Astoria Healthcare Properties, LLC		\$	(2,106,000)	1
2	V	32	Interest	514	Astoria Healthcare Properties, LLC		898,521	898,007	2
3	V	33	Real Estate Taxes		Astoria Healthcare Properties, LLC		333,550	333,550	3
4	V	26	Property Insurance		Astoria Healthcare Properties, LLC		17,600	17,600	4
5	V	36	MIP Expense		Astoria Healthcare Properties, LLC		127,064	127,064	5
6	V	20	Filing Fees		Astoria Healthcare Properties, LLC		370	370	6
7	V	19	Accounting Fees		Astoria Healthcare Properties, LLC		9,571	9,571	7
8	V	19	Legal Fees		Astoria Healthcare Properties, LLC		1,700	1,700	8
9	V	30	Deprecation		Astoria Healthcare Properties, LLC		427,108	427,108	9
10	V	36	Amortization		Astoria Healthcare Properties, LLC		5,404	5,404	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,106,514			\$ 1,820,888	\$ * (285,626)	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	GPN Family Trust	50.00 %	Avantara Arlington	Arlington, SD	Astoria Healthcare Properties, LLC		Building Company	1
2	Doros Generation Trust	50.00 %	Avantara Armour	Armour, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3			Avantara Arrowhead	Rapid City, SD	CF St. Louis LLC	Skokie	Building Company	3
4			Avantara Aurora	Aurora	ML Group Design & Development	Skokie	Asset Management	4
5			Avantara Billings	Billings, MT	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6			Avantara Clark	Clark, SD	Propay HR	Evanston	Payroll Processing	6
7			Avantara Elgin	Elgin	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Evergreen Park	Evergreen Park	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Groton	Groton, SD	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Huron	Huron, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Ipswich	Ipswich, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Lake Norden	Lake Norden, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Long Grove	Long Grove	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Milbank	Milbank, SD				14
15			Avantara Mountainview	Rapid City, SD				15
16			Avantara North	Rapid City, SD				16
17			Avantara Norton	Sioux Falls, SD				17
18			Avantara Park Ridge	Park Ridge				18
19			Avantara Pierre	Pierre, SD				19
20			Avantara Redfield	Redfield, SD				20
21			Avantara Salem	Salem, SD				21
22			Avantara St. Cloud	Rapid City, SD				22
23			Avantara Watertown	Watertown, SD				23
24			Bella Terra Streamwood	Streamwood				24
25			Bella Terra Wheeling	Wheeling				25
26			Bethany Terrace	Morton Grove				26
27			Carlton Skilled Nursing Facility LLC	Chicago				27
28			Chalet Skilled Nursing Facility LLC	Chicago				28
29			Clark Skilled Nursing Facility	Chicago				29
30			Elmbrook Skilled Nursing Facility LLC	Elmhurst				30

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			Evanston Skilled Nursing Facility LLC	Evanston				1
2			Grove at the Lake Skilled Nursing Facility LLC	Zion				2
3			Grove of Berwyn	Berwyn				3
4			Grove of Fox Valley	Aurora				4
5			Grove of St. Charles	St. Charles				5
6			Lagrange Skilled Nursing Facility LLC	Lagrange Park				6
7			Lakefront Skilled Nursing Facility LLC	Chicago				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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 Dietician Salary	\$	Legacy Healthcare Financial Services		\$ 3,079	\$ 3,079	15
16	V	01 Dietary Supplies		Legacy Healthcare Financial Services		16	16	16
17	V	02 Food		Legacy Healthcare Financial Services		5,889	5,889	17
18	V	03 Housekeeping		Legacy Healthcare Financial Services		2,007	2,007	18
19	V	04 Linen Replacement		Legacy Healthcare Financial Services		136	136	19
20	V	06 Maintenance Salary		Legacy Healthcare Financial Services		9,499	9,499	20
21	V	06 Repairs & Maintenance		Legacy Healthcare Financial Services		564	564	21
22	V	10 Nursing Salary		Legacy Healthcare Financial Services		78,623	78,623	22
23	V	10 Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		7,421	7,421	23
24	V	10 Medical Supplies		Legacy Healthcare Financial Services		16,891	16,891	24
25	V	12 Social Service Salary		Legacy Healthcare Financial Services		5,356	5,356	25
26	V	11 Activities Program		Legacy Healthcare Financial Services		8	8	26
27	V	12 Social Service Consultant		Legacy Healthcare Financial Services		21	21	27
28	V	17 COO / Administrative Salary		Legacy Healthcare Financial Services		59,857	59,857	28
29	V	19 Professional Fees		Legacy Healthcare Financial Services		19,651	19,651	29
30	V	20 Dues / Licenses / Permits		Legacy Healthcare Financial Services		3,355	3,355	30
31	V	21 Clerical & General Wages		Legacy Healthcare Financial Services		241,512	241,512	31
32	V	21 Clerical & Office Expense		Legacy Healthcare Financial Services		17,611	17,611	32
33	V	24 Education & Seminars		Legacy Healthcare Financial Services		134	134	33
34	V	25 Travel		Legacy Healthcare Financial Services		4,475	4,475	34
35	V	26 Insurance - General		Legacy Healthcare Financial Services		118	118	35
36	V	27 Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		23,991	23,991	36
37	V	34 Rent		Legacy Healthcare Financial Services		30,293	30,293	37
38	V	34 Offsite Storage / Parking		Legacy Healthcare Financial Services		93	93	38
39	Total		\$			\$ 530,602	\$ * 530,602	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	35	Equipment Rental		Legacy Healthcare Financial Services		404	\$	404
16	V	35	Auto Rental		Legacy Healthcare Financial Services		3,943		3,943
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		5,577		5,577
18	V								
19	V								
20	V								
21	V								
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			9,924	\$ *	9,924

* 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	5	Utilities	\$	CF St. Louis LLC		\$ 1,047	\$ 1,047	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,014	1,014	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		359	359	17
18	V	19	Accounting Fees		CF St. Louis LLC		82	82	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		243	243	20
21	V	26	Insurance		CF St. Louis LLC		263	263	21
22	V	30	Depreciation		CF St. Louis LLC		6,457	6,457	22
23	V	32	Interest Expense		CF St. Louis LLC		3,629	3,629	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		3,297	3,297	24
25	V								25
26	V	34	Rent	30,293	CF St. Louis LLC			(30,293)	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			\$ 30,293			\$ 16,392	\$ * (13,901)	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	Payroll Services	\$ 24,868	ProPay HR LLC		\$ 19,171	\$ (5,697)	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			\$ 24,868			\$ 19,171	\$ * (5,697)	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	06	Maintenance	\$ 34,200	ML Group Design & Development		\$ 33,362	\$ (838)	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			\$ 34,200			\$ 33,362	\$ * (838)	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	Medical Supplies	\$ 9,000	ReMED Services		\$ 6,287	\$ (2,713)	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			\$ 9,000			\$ 6,287	\$ * (2,713)	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	39	Laboratory	\$ 26,159	Lifescan Labs of Illinois		\$ 15,512	\$ (10,647)	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			\$ 26,159			\$ 15,512	\$ * (10,647)	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)

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Ending: 12/31/20

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

()

Facility Name & ID Number Astoria Place Living Rehab# 0053900

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

Legacy Healthcare Financial Services

Street Address

3450 Oakton Street

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847) 679-9797

Fax Number

(847) 683-2900

	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	Dietician Salary	Available Bed Days	2,540,133	53	\$ 130,303	\$ 130,303	60,024	\$ 3,079	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		60,024	16	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		60,024	5,889	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		60,024	2,007	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		60,024	136	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	60,024	9,499	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		60,024	564	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	60,024	78,623	8
9	10	Nurse/Medical Director Consultan	Available Bed Days	2,540,133	53	314,035		60,024	7,421	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		60,024	16,891	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	60,024	5,356	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		60,024	8	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		60,024	21	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	60,024	59,857	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		60,024	19,651	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		60,024	3,355	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	60,024	241,512	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		60,024	17,611	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		60,024	134	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		60,024	4,475	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		60,024	118	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		60,024	23,991	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		60,024	30,293	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		60,024	93	24
25	TOTALS					\$ 22,454,338	\$ 16,839,706		\$ 530,602	25

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

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

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

()

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

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

IL478-2471

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

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	CIBC Bank		X	Mortgage			\$	21,758,392			\$ 898,521	1
2												2
3												3
4												4
5												5
	Working Capital											
6			X	Interest Only							12,800	6
7												7
8												8
9	TOTAL Facility Related						\$	21,758,392			\$ 911,321	9
	B. Non-Facility Related*											
10	Interest Income		X								(13,846)	10
11	Interest Income - Bldg Co		X								(514)	11
12	Allocated from CF St. Louis	X									3,629	12
13												13
14	TOTAL Non-Facility Related						\$				\$ (10,731)	14
15	TOTALS (line 9+line14)						\$	21,758,392			\$ 900,590	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 127,064 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.)

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 2019 report.			\$	338,363	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.)			\$	331,060	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(7,303)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	344,151	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	759	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.			\$	337,607	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	233,006	8	
		2016	254,676	9	
		2017	273,726	10	
		2018	322,251	11	
		2019	327,763	12	
2020 Accrual = \$327,763 x 1.05 = \$344,151					
Allocated from CF St. Louis \$3,297					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$		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.

FACILITY NAME Astoria Place Living Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053900

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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.

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 Astoria Place Living Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053900

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**

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 _____ NO

C. **Tax Bills**

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,536

B. General Construction Type: Exterior BrickFrame WoodNumber 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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 559,576	1
2	Allocated from CF St. Louis, LLC			4,664	2
3	TOTALS			\$ 564,240	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	164		2012	1973	\$ 10,156,976	\$ 427,108	40	\$ 253,924	\$ (173,184)	\$ 2,378,691	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2010		860,768		20	43,038	43,038	506,320	9
10	Various		2011		103,059		20	5,153	5,153	51,703	10
11	Various		2012		66,195		20	3,310	3,310	29,788	11
12	Various		2013		108,957		20	5,448	5,448	43,583	12
13	Various		2014		184,540		20	9,227	9,227	64,589	13
14	Various		2015		246,561		20	12,328	12,328	68,831	14
15	Various		2016		475,067		20	23,753	23,753	95,013	15
16											16
17											17
18											18
19											19
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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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		219,486	5,953		10,436	4,483	46,689	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 12,421,609	\$ 433,061		\$ 366,618	\$ (66,443)	\$ 3,285,206	70

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

Facility Name & ID Number Astoria Place Living Rehab

0053900

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,421,609	\$ 433,061		\$ 366,618	\$ (66,443)	\$ 3,285,206	1
2	Change In Sprinkler Heads	2017	4,605		20	230	230	922	2
3	Replacement Of Cooking System Devices And Materials	2017	2,674		20	134	134	502	3
4	Duct And Roof Work	2017	13,315		20	666	666	2,386	4
5	Caulked Windows	2017	3,500		20	175	175	627	5
6	Electrical & Lighting	2017	4,525		20	226	226	754	6
7	Installed New Copper Type "M" Piping And Fittings, New Ball V	2017	6,495		20	325	325	1,300	7
8	Modify Cabinets And Counter Tops	2017	2,950		20	148	148	542	8
9	Installed New Copper And Brass Flanges	2017	4,760		20	238	238	952	9
10	2 Shunt Trip Breakers, New 120V Control Circuit, New Conduit	2017	3,480		20	174	174	653	10
11	Electrical Work	2017	8,695		20	435	435	1,341	11
12	Replaced Sprinkler Heads	2017	2,834		20	142	142	449	12
13	Install Ceiling Mounted Heater/Volt Feeder - Front Vestibule Area	2018	5,910		20	295	295	1,230	13
14	Fire Alarm System Modification (6990)	2018	6,470		20	323	323	1,646	14
15	Window Graphics (2,552)	2018	2,362		20	118	118	491	15
16	2Nd/3Rd/4Th Flr Resident Bathrooms - Mirrors, Faucet, Doorknob	2018	4,952		20	248	248	896	16
17	2Nd Flr Electrical Work - Install Can Lights (3970)	2018	3,675		20	184	184	665	17
18	4Th Flr Cooling System - Installation,Piping,Wiring (5400)	2018	4,998		20	250	250	860	18
19	Uni-Fit Thru-Wall Air Conditioner (3113)	2018	2,881		20	144	144	510	19
20	Resident Bathroom Mirrors (6107)	2018	5,653		20	283	283	1,481	20
21	Repair Cracked Water Line On A/C System, Door Repair 2Nd,3R	2018	3,934		20	197	197	641	21
22	Plumbing Repairs (12300)	2018	11,385		20	569	569	1,343	22
23	16 Electrical & Lighting Between Finished Ceiling & Drop Ceiling	2019	2,810		20	141	141	249	23
24	Replace 2 New Zoeller 4" Pumps (\$19875)	2019	19,261		20	963	963	1,460	24
25	Hot Water Boiler With New Pump (\$13784.88)	2019	13,359		20	668	668	955	25
26	Hd Camera Systems (\$4029)	2019	3,905		20	195	195	771	26
27	3 Ton Mini Split Fujitsu Units (3 Ac Units) (\$5835.87)	2019	5,656		20	283	283	566	27
28	Compressor And Contactor (\$5980)	2019	5,795		20	290	290	497	28
29	Elevator #1 Furnish & Install New Valve And Gaskets (4,540)	2020	4,429		20	221	221	221	29
30	Basement Flooring (3,600)	2020	3,512		20	176	176	176	30
31	Furnish And Install New Valve In Elevator (7,200)	2020	7,024		20	351	351	351	31
32	Electromagnetic Locks W/ Voice (5,713)	2020	5,573		20	279	279	279	32
33	Installation Of New Call Light System On 4Th Floor (33,207)	2020	32,393		20	1,620	1,620	1,620	33
34	TOTAL (lines 1 thru 33)		\$ 12,635,378	\$ 433,061		\$ 377,306	\$ (55,755)	\$ 3,312,542	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		\$ 12,635,378	\$ 433,061		\$ 377,306	\$ (55,755)	\$ 3,312,542	1
2	Repair Radiator (5,521)	2020	5,386		20	269	269	269	2
3	Pump Motor And Bearing Assembly (3,438)	2020	3,353		20	168	168	168	3
4	Exterior Door In Kitchen Area (7,320)	2020	7,141		20	357	357	357	4
5	Replace Boiler Pump (4,997)	2020	4,875		20	244	244	244	5
6	Repair Bathroom Drain Line & 2Nd Fl Piping (3,175)	2020	3,097		20	155	155	155	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,659,230	\$ 433,061		\$ 378,499	\$ (54,562)	\$ 3,313,735	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		\$ 12,659,230	\$ 433,061		\$ 378,499	\$ (54,562)	\$ 3,313,735	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,659,230	\$ 433,061		\$ 378,499	\$ (54,562)	\$ 3,313,735	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		\$ 12,659,230	\$ 433,061		\$ 378,499	\$ (54,562)	\$ 3,313,735	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
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,659,230	\$ 433,061		\$ 378,499	\$ (54,562)	\$ 3,313,735	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	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
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16									16
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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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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.

Facility Name & ID Number Astoria Place Living Rehab

0053900

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	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	25,111	1,166	35	717	(448)	3,587	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	155,906	3,846	20	7,795	3,949	38,976	9
10	Allocated from CF St. Louis, LLC	2017	3,619	89	20	181	92	724	10
11	Allocated from CF St. Louis, LLC	2019	32,798	809	20	1,640	831	3,280	11
12	Allocated from CF St. Louis, LLC	2019	1,725	43	20	86	44	86	12
13									13
14	Allocated from Legacy HC	2018	186		20	9	9	28	14
15	Allocated from Legacy HC	2020	141		20	7	7	7	15
16									16
17									17
18									18
19									19
20									20
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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)		\$ 219,486	\$ 5,953		\$ 10,436	\$ 4,483	\$ 46,689	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		\$ 219,486	\$ 5,953		\$ 10,436	\$ 4,483	\$ 46,689	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 219,486	\$ 5,953		\$ 10,436	\$ 4,483	\$ 46,689	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	\$ 1,703,899	\$ 503	\$ 169,281	\$ 168,779	10	\$ 782,355	71
72	Current Year Purchases	3,326	2	333	331	10	333	72
73	Fully Depreciated Assets	879,333				10	879,333	73
74								74
75	TOTALS	\$ 2,586,558	\$ 504	\$ 169,614	\$ 169,110		\$ 1,662,021	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)	\$ 15,810,027	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 433,565	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 548,113	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 114,548	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,975,756	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	Architect Fees	\$ 2,410	92
93			93
94			94
95		\$ 2,410	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	Storage				9,600			5
6	Allocated from Legacy Healthcare				93			6
7	TOTAL				\$ 9,693			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: \$ 23,490
- 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	Allocated from Legacy Healthcare		\$	\$ 3,943	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 3,943	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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		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	\$		\$ 240,802	\$		\$ 240,802	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			122,001			122,001	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			293,846			293,846	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				230,578		230,578	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					80,061	142,504		222,565	13
14	TOTAL			\$		\$ 736,710	\$ 373,082		\$ 1,109,792	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	\$ 91,457	\$ 1,050,634	1
2	Cash-Patient Deposits	1,084	1,084	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,747,910	1,747,910	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		58,417	6
7	Other Prepaid Expenses	486,415	486,415	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	238,687	238,687	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,565,553	\$ 3,583,147	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		559,576	13
14	Buildings, at Historical Cost	6,495	10,120,501	14
15	Leasehold Improvements, at Historical Cost	769,813	2,354,381	15
16	Equipment, at Historical Cost	180,292	1,430,737	16
17	Accumulated Depreciation (book methods)	(331,297)	(4,364,478)	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	4,035,318	6,133,183	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,660,621	\$ 16,233,900	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,226,174	\$ 19,817,047	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,154,268	\$ 1,156,336	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		431,081	29
30	Accrued Salaries Payable	307,721	307,721	30
31	Accrued Taxes Payable (excluding real estate taxes)	234,221	234,221	31
32	Accrued Real Estate Taxes(Sch.IX-B)		344,151	32
33	Accrued Interest Payable	2,240	72,955	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,704,574	1,874,973	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,403,024	\$ 4,421,438	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		21,327,311	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,993,830	290,673	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,993,830	\$ 21,617,984	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,396,854	\$ 26,039,422	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,829,320	\$ (6,222,375)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,226,174	\$ 19,817,047	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,101,651	1
2	Restatements (describe):		2
3	Depreciation	98,089	3
4	Rent Expense	185,192	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,384,932	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	230,649	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	(786,261)	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)	\$ (555,612)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,829,320	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Astoria Place Living Rehab

0053900

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	\$ 17,249,593	1
2	Discounts and Allowances for all Levels	(6,946,718)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,302,875	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,493,535	6
7	Oxygen	295	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,493,830	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	223,470	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,205	19
20	Radiology and X-Ray	165	20
21	Other Medical Services	28,638	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 281,478	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,846	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,846	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,249,388	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,249,388	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,341,417	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,430,371	31
32	Health Care	4,909,692	32
33	General Administration	2,495,114	33
	B. Capital Expense		
34	Ownership	2,151,486	34
	C. Ancillary Expense		
35	Special Cost Centers	1,763,444	35
36	Provider Participation Fee	360,661	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,110,768	40
41	Income before Income Taxes (line 30 minus line 40)**	230,649	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 230,649	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,037,277	44
45	Private Pay - Net Inpatient Revenue	460,588	45
46	Medicare - Net Inpatient Revenue	1,543,158	46
47	Other-(specify) Insurance	261,852	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,302,875	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	2,108	2,267	\$ 158,005	\$ 69.70	1
2	Assistant Director of Nursing	1,683	1,810	81,719	45.15	2
3	Registered Nurses	35,475	40,313	1,428,283	35.43	3
4	Licensed Practical Nurses	15,334	17,708	591,412	33.40	4
5	CNAs & Orderlies	69,818	86,424	1,616,854	18.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,384	10,634	272,542	25.63	8
9	Activity Director	1,875	2,023	40,673	20.11	9
10	Activity Assistants	6,643	7,138	103,177	14.46	10
11	Social Service Workers	9,416	10,319	234,777	22.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,720	4,137	95,306	23.04	17
18	Housekeepers					18
19	Laundry	6,598	7,230	109,946	15.21	19
20	Administrator	1,896	2,180	153,859	70.58	20
21	Assistant Administrator	656	831	22,854	27.49	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,172	13,322	250,674	18.82	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	2,548	2,778	71,463	25.72	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	120	135	2,031	15.04	33
34	TOTAL (lines 1 - 33)	179,446	209,249	\$ 5,233,575 *	\$ 25.01	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	Monthly	\$ 1,165,638	01-03	35
36	Medical Director	Monthly	22,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	43,526	10-03	38
39	Pharmacist Consultant	Monthly	5,394	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	Monthly	1,267	11-03	44
45	Social Service Consultant	Monthly	4,306	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 1,242,131		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Netanel Brandman	Asst. Admin	0	\$ 2,179
Ariel Gutnicki	Asst. Admin	0	20,675
Patricia Davis	Administrator	0	153,859
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 176,713
B. Administrative - Other			
Description			Amount
		\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Marcum LLP	Accounting	\$	24,000
ProPay HR	Payroll Processing		24,868
Onyx Procurement Solutions	Procurement Solutions		11,870
Achieve Accreditation	Accreditation		9,227
Telemedicine	Risk Prevention Services		7,817
Baldrige Coach, Inc.	Performance Excellence		900
Compliagent	Compliance Services		1,866
Cortex Health, Inc.	Data Processing		9,320
Elaton Energy Services	Energy Procurement		500
Hygieneering, Inc.	Hygiene & Safety Consulting		1,084
See Attached	Legal		256,552
See Supplemental Schedule			4,006
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 352,011
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	67,257
Unemployment Compensation Insurance			19,170
FICA Taxes			400,368
Employee Health Insurance			210,180
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Union Pension			43,819
Employee Benefits			26,448
401K Expense			14,276
Voluntary Benefits Contribution			18,338
Employee Physical Exams			1,680
TOTAL (agree to Schedule V, line 22, col.8)			\$ 801,536
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	1,990
Advertising: Employee Recruitment			468
Health Care Worker Background Check (Indicate # of checks performed)	131		1,312
Patient Background Checks	540		5,400
Dues & Subscriptions			27,159
Licenses & Fees			684
See Supplemental Schedule			3,356
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 40,369
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			917
See Supplemental Schedule			134
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	1,051

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- | | |
|--|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Yes</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>HCCI \$25,551 ; IHCA \$13,994</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</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>40,534</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>360,661</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>Yes</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</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> |
|--|---|