

Facility Name & ID Number Astoria Place Living & Rehab

0050799 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	164	Skilled (SNF)	164	59,860	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	164	TOTALS	164	59,860	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	42,563	2,941	8,519	54,023	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,563	2,941	8,519	54,023	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.25%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/10

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/10 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 8,213

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number

Astoria Place Living & Rehab

0050799

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	342,805	34,996	23,926	401,727		401,727		401,727		1
2	Food Purchase		418,216		418,216		418,216	20	418,236		2
3	Housekeeping	174,935	40,627		215,562		215,562	1,056	216,618		3
4	Laundry	59,761	23,619		83,380		83,380		83,380		4
5	Heat and Other Utilities			254,717	254,717		254,717	1,221	255,938		5
6	Maintenance	107,478	3,870	128,592	239,940		239,940	3,352	243,292		6
7	Other (specify):*										7
8	TOTAL General Services	684,978	521,328	407,235	1,613,542		1,613,542	5,649	1,619,191		8
	B. Health Care and Programs										
9	Medical Director			65,500	65,500		65,500		65,500		9
10	Nursing and Medical Records	3,146,636	201,455	173,116	3,521,207		3,521,207	(43,838)	3,477,369		10
10a	Therapy	4,785			4,785		4,785		4,785		10a
11	Activities	117,387	8,874	2,016	128,277		128,277		128,277		11
12	Social Services	152,197		18,372	170,569		170,569	5,477	176,046		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							268	268		15
16	TOTAL Health Care and Programs	3,421,005	210,329	259,004	3,890,338		3,890,338	(38,093)	3,852,245		16
	C. General Administration										
17	Administrative	161,612		734,828	896,440		896,440	(690,902)	205,538		17
18	Directors Fees										18
19	Professional Services			207,910	207,910		207,910	24,961	232,871		19
20	Dues, Fees, Subscriptions & Promotions			24,485	24,485		24,485	(6,355)	18,130		20
21	Clerical & General Office Expenses	280,374	(12,813)	313,235	580,796		580,796	(125,797)	454,999		21
22	Employee Benefits & Payroll Taxes			861,507	861,507		861,507		861,507		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,959	6,959		6,959	(4,960)	1,999		24
25	Other Admin. Staff Transportation			21,546	21,546		21,546	1,305	22,851		25
26	Insurance-Prop.Liab.Malpractice			165,817	165,817		165,817	1,121	166,938		26
27	Other (specify):* Mgmt Alloc of Benefi							31,892	31,892		27
28	TOTAL General Administration	441,986	(12,813)	2,336,287	2,765,460		2,765,460	(768,735)	1,996,725		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,547,970	718,844	3,002,526	8,269,340		8,269,340	(801,179)	7,468,161		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Astoria Place Living & Rehab

#0050799

Report Period Beginning:

01/01/13

Ending:

12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			175,202	175,202	175,202	547,953	723,155				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,026	23,026	23,026	696,439	719,465				32
33	Real Estate Taxes			183,980	183,980	183,980	3,271	187,251				33
34	Rent-Facility & Grounds			1,039,200	1,039,200	1,039,200	(1,039,200)					34
35	Rent-Equipment & Vehicles			62,521	62,521	62,521		62,521				35
36	Other (specify):*											36
37	TOTAL Ownership			1,483,929	1,483,929	1,483,929	208,463	1,692,392				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		342,252	819,051	1,161,303	1,161,303	(2,000)	1,159,303				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			283,846	283,846	283,846		283,846				42
43	Other (specify):* Non-Allowable Co	98,943		564,990	663,933	663,933	(663,933)					43
44	TOTAL Special Cost Centers	98,943	342,252	1,667,887	2,109,082	2,109,082	(665,933)	1,443,149				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,646,913	1,061,096	6,154,343	11,862,352	11,862,352	(1,258,649)	10,603,703				45

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

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0050799

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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	(34,597)	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	110,898	30		9
10	Interest and Other Investment Income	(252)	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	(1,834)	43		18
19	Entertainment				19
20	Contributions	(91,049)	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	(177,619)	43		24
25	Fund Raising, Advertising and Promotional	(87,353)	43		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	(283,470)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (565,276)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(693,373)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (693,373)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,258,649)		37

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

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

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

Astoria Place Living & Rehab

ID# 0050799

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Medicaid Tax	\$ (89,790)	43	1
2	Lab & Radiology	(12,023)	43	2
3	Drugs	(6,895)	43	3
4	Patient pers. Items	(1,125)	43	4
5	Admitting	(98,943)	43	5
6	Sequestration	(59,630)	43	6
7	Adj Prior Year Expenses	9,607	43	7
8	Charity	(12,682)	43	8
9	Disallow Travel & Seminar	(5,021)	24	9
10	Disallow Lobbying Expense	(6,968)	20	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(283,470)	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
See Pg 6-Supp		See Pg 6-Supp		See Pg6-Supp		

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2 Dietary	\$	Legacy Healthcare Financial Services, LLC	100.00%	\$ 20	\$ 20	1
2	V	3 Housekeeping Salaries		Legacy Healthcare Financial Services, LLC	100.00%	942	942	2
3	V	3 Housekeeping Supplies		Legacy Healthcare Financial Services, LLC	100.00%	114	114	3
4	V	5 Utilities		Legacy Healthcare Financial Services, LLC	100.00%	1,221	1,221	4
5	V	6 Repairs & Maintenance		Legacy Healthcare Financial Services, LLC	100.00%	3,352	3,352	5
6	V	10 Nursing Salary		Legacy Healthcare Financial Services, LLC	100.00%			6
7	V	17 Administrative Salary - Mgmt Alloc	734,828	Legacy Healthcare Financial Services, LLC	100.00%	29,568	(705,260)	7
8	V	19 Other Professional Fees		Legacy Healthcare Financial Services, LLC	100.00%	3,358	3,358	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%	2,633	2,633	10
11	V	19 Data Processing		Legacy Healthcare Financial Services, LLC	100.00%	2,523	2,523	11
12	V	20 Dues, Licenses, & Fees		Legacy Healthcare Financial Services, LLC	100.00%	559	559	12
13	V	21 Office Supplies	264,000	Legacy Healthcare Financial Services, LLC	100.00%	10,716	(253,284)	13
14	Total		\$ 998,828			\$ 55,006	\$ * (943,822)	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%	\$ 125,727	\$ 125,727
16	V	24 Travel		Legacy Healthcare Financial Services, LLC	100.00%	1,305	1,305
17	V	25 Education & Seminars		Legacy Healthcare Financial Services, LLC	100.00%		
18	V	26 Insurance Expense		Legacy Healthcare Financial Services, LLC	100.00%	1,121	1,121
19	V	27 Employee Benefits - Mgmt Alloc		Legacy Healthcare Financial Services, LLC	100.00%	31,203	31,203
20	V	30 Depreciation Expense		Legacy Healthcare Financial Services, LLC	100.00%	2,590	2,590
21	V	32 Interest Expense		Legacy Healthcare Financial Services, LLC	100.00%	18	18
22	V	33 Real Estate Taxes		Legacy Healthcare Financial Services, LLC	100.00%		
23	V	34 Rent Expense		Legacy Healthcare Financial Services, LLC	100.00%	9,793	9,793
24	V	35 Equipment Rental		Legacy Healthcare Financial Services, LLC	100.00%		
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		\$			\$ 171,757	\$ * 171,757

* 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	30 Depreciation	\$	Legacy Real Properties, LLC	100.00%	\$ 3,711	\$	3,711	15
16	V	32 Interest		Legacy Real Properties, LLC	100.00%	3,101		3,101	16
17	V	33 Real Estate Taxes		Legacy Real Properties, LLC	100.00%	3,271		3,271	17
18	V	20 Dues & Subscriptions		Legacy Real Properties, LLC	100.00%	27		27	18
19	V	34 Rent	9,793	Legacy Real Properties, LLC	100.00%			(9,793)	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		\$ 9,793			\$ 10,110	\$ *	317	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	10 RN Salary	\$ 54,000	Progressive Healthcare Consulting	100.00%	\$ 10,162	\$ (43,838)
16	V	12 Clergy Salary		Progressive Healthcare Consulting	100.00%	671	671
17	V	12 Admission Salary		Progressive Healthcare Consulting	100.00%	4,806	4,806
18	V	17 Administrator		Progressive Healthcare Consulting	100.00%	14,358	14,358
19	V	19 Professional Fees		Progressive Healthcare Consulting	100.00%	327	327
20	V	20 Fees and Subscriptions		Progressive Healthcare Consulting	100.00%	27	27
21	V	21 Clerical & General		Progressive Healthcare Consulting	100.00%	473	473
22	V	15 Emp. Ben - Nursing		Progressive Healthcare Consulting	100.00%	268	268
23	V	27 Employee Benefits - Mgmt Alloc		Progressive Healthcare Consulting	100.00%	687	687
24	V	21 Trainor Salary		Progressive Healthcare Consulting	100.00%	1,302	1,302
25	V	24 Education & Seminar		Progressive Healthcare Consulting	100.00%	61	61
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		\$ 54,000			\$ 33,142	\$ * (20,858)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 Professional Fees	\$	Astoria Real Properties, LLC	100.00%	\$ 500	\$	500	15
16	V	19 Legal Fees		Astoria Real Properties, LLC	100.00%	11,330		11,330	16
17	V	20 Dues and Subscriptions		Astoria Real Properties, LLC	100.00%				17
18	V	21 Bank Service Charge	15	Astoria Real Properties, LLC	100.00%			(15)	18
19	V	30 Depreciation		Astoria Real Properties, LLC	100.00%	430,866		430,866	19
20	V	32 Interest	110	Astoria Real Properties, LLC	100.00%	665,962		665,852	20
21	V	32 Loan Fees		Astoria Real Properties, LLC	100.00%	27,610		27,610	21
22	V	33 Real Estate Tax		Astoria Real Properties, LLC	100.00%	183,980		183,980	22
23	V	34 Rent	1,223,180	Astoria Real Properties, LLC	100.00%			(1,223,180)	23
24	V	19 Accounting Fees		Astoria Real Properties, LLC	100.00%	4,290		4,290	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		\$ 1,223,305			\$ 1,324,538	\$ *	101,233	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	39 Ambulance	\$ 11,443	Lifeline Ambulance	100.00%	\$ 9,443	\$ (2,000)
16	V						
17	V						
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		\$ 11,443			\$ 9,443	\$ * (2,000)

* 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:

01/01/13

Ending:

12/31/13

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	30.5	Grove of Northbrook Living & Rehab	Northbrook	Legacy Healthcare	Lincolnwood	Management Co.	1
2	Menachem Shabat	30.5	Renaissance Park South	Chicago	Financial Svcs, LLC			2
3	Rajchenbach Family Trust	14.5	Warren Barr Living & Rehab Ctr	Chicago				3
4	Ronald Shabat	14.5	Grove Lincoln Park Living & Rehab Ctr	Chicago	Legacy Real	Lincolnwood	Real Estate	4
5	Howard & Shari Borenstein	10	The Villa At Evergreen Park	Evergreen Park	Properties, LLC			5
6			Peterson Park Health Care Ctr	Chicago				6
7			Pine Acres Rehab & Living Ctr	Dekalb	Grove Healthcare	Lincolnwood	Real Estate	7
8			Park Villa Nursing & Rehab Ctr	Palos Heights	Properties, LLC			8
9			Grove At The Lake Living & Rehab	Zion				9
10			Chalet Living & Rehab Center	Chicago	Remed Services,	Lincolnwood	Medical	10
11			The Grove of Evanston	Evanston	LLC		Equipment Sales	11
12			The Grove of Skokie Living & Rehab	Skokie				12
13			Elmbrook Nursing	Elmhurst	Progressive	Lincolnwood	Consulting	13
14			Lakefront Nursing & Rehab Center	Chicago	Healthcare			14
15			Florence Nursing Home	Marengo	Consulting			15
16			The Villa at Windsor Park	Chicago				16
17					Astoria Real	Lincolnwood	Real Estate	17
18					Property, LLC			18
19								19
20					Lifeline Ambulance	Chicago	Ambulance	20
21							Services	21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	30.50	See Attached	See Att.	See Att.	Mgmt. Salary	\$ 14,784	17(3)	1
2	Menachem Shabat	Owner	Administrative	30.50	See Attached	See Att.	See Att.	Mgmt. Salary	14,784	17(3)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 29,568		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:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Dietary	Patient Days	809,780	17	\$ 271	\$ 59,860	\$ 20	1	
2	3	Housekeeping Salaries	Patient Days	809,780	17	12,745	59,860	942	2	
3	3	Housekeeping Supplies	Patient Days	809,780	17	1,546	59,860	114	3	
4	5	Utilities	Patient Days	809,780	17	16,531	59,860	1,221	4	
5	6	Repairs & Maintenance	Patient Days	809,780	17	45,337	59,860	3,352	5	
6	10	Nursing Salary	Patient Days	809,780	17		59,860	0	6	
7	17	Administrative Salary - Mgmt All	Hours	100	17	400,000	400,000	7	29,568	7
8	19	Other Professional Fees	Patient Days	809,780	17	115,181	59,860	8,514	8	
9									9	
10									10	
11	20	Dues, Licenses, & Fees	Patient Days	809,780	17	7,563	59,860	559	11	
12	21	Office Supplies	Patient Days	809,780	17	1,845,747	1,700,817	59,860	136,443	12
13									13	
14	24	Education & Seminars	Patient Days	809,780	17	17,652	59,860	1,305	14	
15									15	
16	26	Insurance Expense	Patient Days	809,780	17	15,170	59,860	1,121	16	
17	27	Employee Benefits - Mgmt Alloc	Patient Days	809,780	17	289,128	59,860	21,373	17	
18	27	Employee Benefits - Mgmt Alloc	Bed Days Available	100	17	133,004	7	9,832	18	
19	30	Depreciation Expense	Patient Days	809,780	17	35,039	59,860	2,590	19	
20	32	Amortization Expense	Patient Days	809,780	17	242	59,860	18	20	
21									21	
22	34	Rent Expense	Patient Days	809,780	17	132,473	59,860	9,793	22	
23									23	
24									24	
25	TOTALS					\$ 3,067,629	\$ 2,113,562	\$ 226,765	25	

Facility Name & ID Number Astoria Place Living & Rehab

0050799

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
10	RN Salary	Patient Days	550,071	10	\$ 93,385	\$ 10,162	59,860	\$ 10,162	1
12	Clergy Salary	Patient Days	550,071	10	6,165	671	59,860	671	2
17	Administrator	Patient Days	550,071	10	131,937	131,937	59,860	14,358	3
19	Professional Fees	Patient Days	550,071	10	3,003	327	59,860	327	4
20	Fees and Subscriptions	Patient Days	550,071	10	250	27	59,860	27	5
21	Clerical & General	Patient Days	550,071	10	16,314	1,775	59,860	1,775	6
15	Emp. Ben - Nursing	Patient Days	550,071	10	2,467	268	59,860	268	7
12	Admissions Salary	Patient Days	550,071	10	44,165	4,806	59,860	4,806	8
27	Employee Benefits - Mgmt Alloc	Patient Days	550,071	10	6,314	687	59,860	687	9
24	Education & Seminar	Patient Days	550,071	10	560	61	59,860	61	10
									11
									12
									13
									14
									15
									16
									17
									18
									19
									20
									21
									22
									23
									24
25	TOTALS				\$ 304,560	\$ 150,721		\$ 33,142	25

Facility Name & ID Number Astoria Place Living & Rehab

0050799

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Lifeline Ambulance
 Street Address 2424 S. Wabash Ave
 City / State / Zip Code Chicago, IL 60616
 Phone Number (312) 949-9595
 Fax Number (312) 949-9262

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ambulance	Direct Allocation		\$	\$		\$ 9,443	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				\$	\$		\$ 9,443	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	02/02/14	0.0220	\$ 27,610	1						
2	The Private Bank		X	Mortgage		8/30/12	12,600,000	12,600,000	9/1/42	Varies	638,750	2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7	The Private Bank		X	Line of Credit	Varies	03/03/10		820,000	3/3/14	0.0600	23,026	7						
8												8						
9	TOTAL Facility Related				\$1,008.33		\$ 13,100,000	\$ 13,920,000			\$ 689,386	9						
B. Non-Facility Related*																		
10											Allocated from related parties	30,331	10					
11											Interest income offset	(252)	11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$ 30,079	14						
15	TOTALS (line 9+line14)						\$ 13,100,000	\$ 13,920,000			\$ 719,465	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 2012 report.			\$ <u>111,336</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.)	2012		\$ <u>175,726</u>	2																				
3. Under or (over) accrual (line 2 minus line 1).			\$ <u>64,390</u>	3																				
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <u>119,590</u>	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.)		Allocated from Mgmt Co.	<u>3,271</u>	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>187,251</u>	7																				
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2008	8	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012</td> <td style="text-align: right;">\$ _____</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$ _____</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$ _____</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$ _____</td> <td style="text-align: center;">16</td> </tr> </table>			FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2012	\$ _____	13	14	PLUS APPEAL COST FROM LINE 5	\$ _____	14	15	LESS REFUND FROM LINE 6	\$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$ _____	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2012	\$ _____				13																		
14	PLUS APPEAL COST FROM LINE 5	\$ _____				14																		
15	LESS REFUND FROM LINE 6	\$ _____				15																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$ _____	16																					
	2009	9																						
	2010	<u>146,865</u>	10																					
	2011	<u>259,835</u>	11																					
	2012	<u>175,726</u>	12																					
Accrual based on unpaid 2013 taxes due in 2014																								
Real estate taxes for FY 13 include \$114,581.16 paid in 2013 and \$108,717 in 2012 less refunds of \$(47,573)																								

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.

2012 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 Chaim Rajchenbach
 TELEPHONE (773) 248-6000 FAX #: (773) 248-9703

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>13-01-107-030-0000</u>	<u>Nursing Home</u>	\$ <u>100,456.94</u>	\$ <u>100,456.94</u>
2. <u>10-35-104-076-0000</u>	<u>Real Estate Entity</u>	\$ <u>21,199.41</u>	\$ <u>3,271.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>121,656.35</u></u>	\$ <u><u>103,727.94</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

Facility Name & ID Number Astoria Place Living & Rehab

0050799 Report Period Beginning:

01/01/13 Ending:

12/31/13

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	<u>Allocated from Legacy Real Properties</u>			<u>\$ 6,048</u>	1
2	<u>Allocated from Astoria Real Properties</u>			<u>559,576</u>	2
3	TOTALS			\$ 565,624	3

Facility Name & ID Number Astoria Place Living & Rehab

0050799

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		Allocation of Purchase Price	2012	1974	\$ 10,114,005	\$	40	\$ 252,850	\$ 252,850	\$ 339,999	4
5		Allocated from Legacy Healthcare Financial Services			89,826			2,149	2,149	7,028	5
6											6
7											7
8											8
		Improvement Type**									
9		Door System and Locks	2010		6,590		10	659	659		9
10		Roofing	2010		10,125		10	1,013	1,013	3,544	10
11		Landscape Irrigation System	2010		6,500		10	650	650	2,275	11
12		Resident Room Built-in Furniture	2010		84,920		15	5,661	5,661	19,815	12
13		Office Furniture	2010		6,071		15	405	405	1,416	13
14		Carpeting	2010		15,513		5	3,103	3,103	10,859	14
15		Fire Alarm System	2010		19,877		10	1,988	1,988	6,958	15
16		Electrical	2010		17,930		20	896	896	3,136	16
17		Admin Bathroom	2010		8,450		20	422	422	1,477	17
18		Millwork	2010		59,488		15	3,966	3,966	13,881	18
19		Painting and drywall	2010		16,878		5	3,376	3,376	11,816	19
20		Waterfountain	2010		1,275		10	128	128	448	20
21		Improvements	2010		26,520		20	1,326	1,326	4,641	21
22		Therapy Room Remodel	2010		10,375		20	519	519	1,815	22
23		Plumbing	2010		23,585		20	1,179	1,179	4,128	23
24		Tile and Installation	2010		40,616		10	4,062	4,062	14,217	24
25		Grease Trap	2010		14,150		10	1,415	1,415	4,954	25
26		Phone System	2010		7,000		10	700	700	2,450	26
27		Elevator	2010		3,874		20	194	194	679	27
28		Windows	2010		209,850		20	10,493	10,493	36,724	28
29		1st Floor Rehab	2010		111,411		20	5,571	5,571	19,497	29
30		Satellite	2010		12,500		10	1,250	1,250	4,375	30
31		PT Room	2010		13,247		10	1,325	1,325	4,636	31
32		Window Drapes	2010		31,707		5	6,341	6,341	22,195	32
33		Resident Room & Rehab	2010		56,575		20	2,828	2,828	9,898	33
34		Electronic	2010		16,265		20	813	813	2,847	34
35		Family Dining	2010		7,000		20	350	350	1,225	35
36		Rehab Bathrooms	2010		7,808		10	781		2,732	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:

01/01/13

Ending:

12/31/13

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	\$ 10,458	37
38	Signs	2010	24,203		10	2,420	2,420	8,470	38
39	Light Fixtures	2010	7,475		10	748	748	2,618	39
40	Window Guards	2010	3,800		20	190	190	665	40
41	New Fence	2010	23,922		15	1,595	1,595	5,581	41
42	Library	2010	36,204		20	1,810	1,810	6,335	42
43	Tuckpointing	2010	7,315		20	365	365	1,279	43
44	Architectural Design	2010	1,237		10	123	123	432	44
45	Nurses Station	2010	14,000		15	933	933	3,267	45
46	New Fire Pump	2010	4,236		20	212	212	742	46
47	Entrance Rehab (doors, automatic entrance, sconces and tile)	2010	37,684		10	3,768	3,768	13,188	47
48	2nd Floor Rehab (hand rails, carpeting)	2010	17,171		20	858	858	3,003	48
49	Parking Lot	2010	5,491		10	549	549	1,923	49
50	Landscaping	2010	28,850		10	2,885	2,885	10,099	50
51	Fire Pump Repairs	2011	2,965		20	148	148	370	51
52	2nd Floor Corridor Rehab	2011	24,879		20	1,244	1,244	3,110	52
53	2 New Elevators	2011	6,781		20	339	339	848	53
54	Plumbing Maintenance	2011	3,590		20	180	180	450	54
55	Dayroom - Roller Shades, Dining Room - Table Cloths	2011	4,281		5	856	856	2,140	55
56	Handrail End Caps, Rollershades, Elevator Floor (Removed Old, I	2011	10,790		5	2,158	2,158	5,395	56
57	Location and Room Signs	2011	5,927		10	593	593	1,482	57
58	Location and Room Signs	2011	6,082		10	608	608	1,520	58
59	Rehab Room Renovation	2011	10,000		20	500	500	1,250	59
60	Back-Up Generator Upkeep	2011	3,100		20	155	155	388	60
61	Rehab Room Renovation (#2)	2011	19,350		20	968	968	2,420	61
62	Rehab Room Renovation (#3)	2011	9,400		20	470	470	1,175	62
63	Elevator Maintenance	2011	2,930		20	147	147	367	63
64									64
65	Sprinkler upgrade	2012	10,888		20	544	544	816	65
66	Railing bars for existing stairways	2012	6,900		20	345	345	518	66
67	Relocate doors	2012	3,530		20	177	177	265	67
68	Fire dampers	2012	22,351		20	1,118	1,118	1,677	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,430,206	\$		\$ 346,406	\$ 345,625	\$ 651,915	70

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

Facility Name & ID Number Astoria Place Living & Rehab

0050799

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,430,206	\$		\$ 346,406	\$ 346,406	\$ 651,915	1
2	Electrical work	2012	5,709		20	285	285	428	2
3	Sign	2012	11,547		10	1,155	1,155	1,732	3
4	Electrical	2012	5,270		20	264	264	396	4
5	Design fees	2012	4,781		5	956	956	1,434	5
6									6
7	Doctors office upgrade	2013	6,025		20	151	151	151	7
8	3 ton air cooled condenser	2013	8,788		20	220	220	220	8
9	Sprinkler work	2013	5,472		20	137	137	137	9
10	Fix closed doors	2013	3,450		20	86	86	86	10
11	2nd & 3rd floor air conditioners	2013	9,299		20	232	232	232	11
12	AC for laundry area	2013	8,977		20	224	224	224	12
13	Lobby AC replacement	2013	13,678		20	342	342	342	13
14	Replace 2nd floor dropceiling	2013	15,875		20	397	397	397	14
15	2 hot water tanks	2013	21,888		20	547	547	547	15
16	Sprinkler work	2013	4,080		20	102	102	102	16
17	Replaced sanitary sewer line	2013	8,750		20	219	219	219	17
18	Injector pump replaced	2013	2,675		20	67	67	67	18
19	Allocated from Legacy Real Properties	2009	26,609			665	665	4,989	19
20	Allocated from Legacy Real Properties	2010	8,091			263	263	1,134	20
21	Allocated from Legacy Real Properties	2011	11,500			575	575	1,725	21
22	Allocated from Legacy Healthcare Financial Services	2012	2,108			222	222	211	22
23	Allocated from Legacy Healthcare Financial Services	2013	6,742			930	930	337	23
24									24
25									25
26	Tie To Book Deprecation			175,202			(175,202)		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,621,520	\$ 175,202		\$ 354,445	\$ 179,243	\$ 667,025	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	\$ 1,144,377	\$	\$ 169,823	\$ 169,823	3-7 yrs	\$ 328,600	71
72	Current Year Purchases	230,198		23,020	23,020	5 yrs	23,020	72
73	Fully Depreciated Assets							73
74	See Schedule 13A	899,452		175,867	175,867	7	240,732	74
75	TOTALS	\$ 2,274,027	\$	\$ 368,710	\$ 368,710		\$ 592,352	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,461,171	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 175,202	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 723,155	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 547,953	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,259,377	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.

Astoria Place Living & Rehab Center

0050799

12/31/2013

Schedule 13A

Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
1 Allocation from LHFS, Inc	7,918		1,643	1,643	7	1,643
2 Allocated from Legacy Real Properties	12,201		4,600	4,600	7	4,600
3 Astoria Real Properties, LLC	879,333		169,624	169,624	7	234,489
Total - Line 74	899,452	-	175,867	175,867		240,732

Facility Name & ID Number Astoria Place Living & Rehab

0050799

Report Period Beginning: 01/01/13

Ending: 12/31/13

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			<u>N/A</u>					5
6								6
7	TOTAL				\$			7

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. <u> /2014</u>	\$ <u>957,760</u>
------------------------------------	-------------------

13. <u> /2015</u>	\$ <u> </u>
------------------------------------	------------------------------

14. <u> /2016</u>	\$ <u> </u>
------------------------------------	------------------------------

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: \$ 62,521 Description: Nursing Equipment: \$60,993; Postage Machine \$628; other equipment \$900

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/13 Ending: 12/31/13
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39(2)	hrs	\$	14,531	\$ 290,618	\$	14,531	\$ 290,618	1	
2	Licensed Speech and Language Development Therapist	39(2)	hrs		5,038	100,766		5,038	100,766	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39(2)	hrs		20,937	418,730		20,937	418,730	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 prescripts				342,252		342,252	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>Ambulance</u>				447	8,937		447	8,937	12	
13	Other (specify):									13	
14	TOTAL			\$	40,953	\$ 819,051	\$ 342,252	40,953	\$ 1,161,303	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Astoria Place Living & Rehab# 0050799Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (18,617)	\$ 514,176	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>321,388</u>)	3,157,965	3,157,965	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,480	106,480	6
7	Other Prepaid Expenses	75,925	137,442	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See SCH 17A</u>	11,097	11,097	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,332,850	\$ 3,927,160	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		565,624	13
14	Buildings, at Historical Cost		10,203,832	14
15	Leasehold Improvements, at Historical Cost	1,358,218	1,417,688	15
16	Equipment, at Historical Cost	516,753	2,274,027	16
17	Accumulated Depreciation (book methods)	(496,707)	(1,259,377)	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)	\$ 1,378,264	\$ 13,201,794	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,711,115	\$ 17,128,955	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 305,953	\$ 305,953	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	543,898	543,898	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		119,590	32
33	Accrued Interest Payable		54,250	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See SCH 17A</u>	3,310,868	2,971,422	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,160,719	\$ 3,995,113	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	820,000	1,320,000	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)	\$ 820,000	\$ 13,920,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,980,719	\$ 17,915,113	46
47	TOTAL EQUITY (page 18, line 24)	\$ (269,605)	\$ (786,159)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,711,115	\$ 17,128,955	48

*(See instructions.)

Astoria Place Living & Rehab Center
0050799
12/31/2013

Schedule 17A

Line 9

116.9 CIP	3,715	3,715
119.1 Security Deposits	2,587	2,587
124.0 Leg Charity	(11,433)	(11,433)
121.4 IL B L F	22,140	22,140
126.0 Due To/From Progressive	8,816	8,816
122.1 State UC tax	(14,728)	(14,728)
Total to L 9	<u>11,097</u>	<u>11,097</u>

Line 36

10.0 TRUST CLEARING ACCT	7,770	7,770
111.0 REFUND - TRANSFER	1,510	1,510
120.7 DUE TO MEDICARE	134,818	134,818
121.0 ACCRUED SEQSTR	5,258	5,258
121.5 STATE ASSESSMENT FEE	(25,069)	(25,069)
121.9 ACRD MGT FEES	77,333	77,333
122.2 FED UNEMP TAX	1,093	1,093
122.5 ACCRUED F I C A	14,798	14,798
123.0 F I C A WITHHELD	0	0
123.1 FED WITHHOLD TAX	0	0
123.3 ILLINOIS W/H	52	52
123.5 UNION DUES PAYABLE	(1,679)	(1,679)
123.6 DUE TO OTHERS	12,000	12,000
124.7 LP	995	995
124.8 DUE TO/FROM RELATED	16,804	(322,642)
125.0 T/F GHCP	1,206	1,206
124.9 AHCP	339,446	339,446
398.0 SPECIAL HDSI RETAINER	2,724,533	2,724,533
Total to L 36	<u>3,310,868</u>	<u>2,971,422</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 975,859	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(975,859)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	380,395	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	(650,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (269,605)	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)	\$ (269,605)	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,885,163	1
2	Discounts and Allowances for all Levels	(1,180,111)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,705,052	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,204,333	6
7	Oxygen	2,400	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,206,733	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	321,055	17
18	Sale of Supplies to Non-Patients	1,607	18
19	Laboratory	1,418	19
20	Radiology and X-Ray	6,740	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 330,820	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	142	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 142	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)	\$ 12,242,747	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,613,542	31
32	Health Care	3,890,338	32
33	General Administration	2,765,460	33
B. Capital Expense			
34	Ownership	1,483,929	34
C. Ancillary Expense			
35	Special Cost Centers	1,825,236	35
36	Provider Participation Fee	283,846	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,862,352	40
41	Income before Income Taxes (line 30 minus line 40)**	380,395	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 380,395	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,527,425	44
45	Private Pay - Net Inpatient Revenue	1,112,033	45
46	Medicare - Net Inpatient Revenue	3,245,705	46
47	Other-(specify) <u>Contractual Adj</u>	(1,180,111)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,705,052	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.

^ Cash basis taxpayer

Facility Name & ID Number Astoria Place Living & Rehab

0050799

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	2,390	2,589	\$ 122,062	\$ 47.15	1
2	Assistant Director of Nursing	1,997	2,116	76,391	36.10	2
3	Registered Nurses	27,668	30,669	880,580	28.71	3
4	Licensed Practical Nurses	26,514	28,830	721,607	25.03	4
5	CNAs & Orderlies	91,101	98,663	1,118,079	11.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,739	8,537	144,463	16.92	8
9	Activity Director	1,859	1,914	32,749	17.11	9
10	Activity Assistants	5,676	5,995	84,638	14.12	10
11	Social Service Workers	5,924	6,275	152,197	24.25	11
12	Dietician					12
13	Food Service Supervisor	3,917	4,182	83,802	20.04	13
14	Head Cook	3,973	4,391	68,418	15.58	14
15	Cook Helpers/Assistants	17,237	18,687	190,585	10.20	15
16	Dishwashers					16
17	Maintenance Workers	7,759	11,900	107,478	9.03	17
18	Housekeepers	13,728	14,819	174,935	11.80	18
19	Laundry	4,545	4,413	59,761	13.54	19
20	Administrator	1,431	1,686	86,418	51.26	20
21	Assistant Administrator	1,839	2,165	75,194	34.73	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	33,747	35,229	379,317	10.77	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	4,044	4,038	88,239	21.85	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	263,088	287,098	\$ 4,646,913 *	\$ 16.19	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	464	\$ 23,926	1(3)	35
36	Medical Director	Monthly	65,500	9(3)	36
37	Medical Records Consultant	Monthly	3,760	10(3)	37
38	Nurse Consultant	990	67,000	10(3)	38
39	Pharmacist Consultant	Monthly	11,301	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	2,016	11(3)	44
45	Social Service Consultant	123	7,272	12(3)	45
46	Other(specify) <u>MDS Consulting</u>				46
47	<u>MDS Consultant</u>	Monthly	62,623	10(3)	47
48	<u>Medical Consultant</u>	Monthly	5,000	10(3)	48
49	TOTAL (lines 35 - 48)	1,577	\$ 248,398		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	1,339	23,432	10(3)	52
53	TOTAL (lines 50 - 52)	1,339	\$ 23,432		53

Facility Name & ID Number Astoria Place Living & Rehab

0050799

Report Period Beginning: 01/01/13

Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Patricia Davis	Administrator	0	\$ 86,418	Workers' Compensation Insurance	\$ 134,300	IDPH License Fee	\$ 4,389	
Zinal Patel	Asst. Administrator	0	60,252	Unemployment Compensation Insurance	129,259	Advertising: Employee Recruitment	48	
Aaron Cohen	Asst Administrator	0	14,942	FICA Taxes	340,679	Health Care Worker Background Check		
				Employee Health Insurance	216,082	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	176 2,107	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	1,951	
				Union Pension	12,743	IL Council on Long Term Care Dues	15,990	
				Uniforms	19,794	Allocation from Legacy Healthcare	613	
						Less: Lobbying Expense	(6,968)	
TOTAL (agree to Schedule V, line 17, col. 1)				Other Employee Benefits	8,650			
(List each licensed administrator separately.)			\$ 161,612			Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other								
Description			Amount	TOTAL (agree to Schedule V,			TOTAL (agree to Sch. V,	
Management Fees			\$ 734,828	line 22, col.8)			line 20, col. 8)	
Eliminated on Sch V Col 7				\$ 861,507			\$ 18,130	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 734,828	E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				to Owners or Employees				
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type	Amount						
AT&T	Data Processing	\$ 223		N/A			Out-of-State Travel	\$
Health Data System, Inc	Data Processing	9,304						
Comcast Cable	Data Processing	128						
Creative Technology	Data Processing	9,261					In-State Travel	
Wescom Solution	Data Processing	14,379					Seminar Expense	1,938
Legacy Reimbursements	Data Processing	3,194						
Joint Commission	Data Processing	59					Seminar Expense	
McGladrey LLP	Accounting Fees	28,707					Allocation from Legacy Healthcare	61
Krupnick, Bokor & Kagda	Accounting Fees	1,125						
Legacy FR&R	Accounting Fees	640					Entertainment Expense	()
See Sch 21C	Various	140,889					(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			line 24, col. 8)	\$ 1,999
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 207,910	\$				

* Attach copy of IMRF notifications

**See instructions.

Astoria Place Living and Rehab
 FYE: 12/31/13
 Medicaid Cost Report Workpapers

Schedule 21A - Other Professional Fees

<u>Vendor</u>	<u>Type of Service</u>	<u>Amount</u>
CORPORATION SERVICE COMPANY	Legal	118
CORPORATION SERVICE COMPANY	Legal	118
Law offices of Patricia Hogan	Legal	675
LAW OFFICE OF EVELYN HOFFMANN,	Legal	1,006
LAW OFFICES OF THOMAS E.	Legal	938
MEYER MAGENCE	Legal	63
MEYER MAGENCE	Legal	188
MEYER MAGENCE	Legal	563
MEYER MAGENCE	Legal	125
MEYER MAGENCE	Legal	63
MEYER MAGENCE	Legal	125
MUCH SHELIST	Legal	104
MUCH SHELIST	Legal	69
MUCH SHELIST	Legal	322
MUCH SHELIST	Legal	35
OGLETREE, DEAKINS, NASH,	Legal	3,303
OGLETREE, DEAKINS, NASH,	Legal	68
RECLASS LEGAL FEES WITH RE TAX REDUCTION	Legal	15,546
SHERYL E. FUHR & ASSOCIATES	Legal	2,197
SKIDELS KY & ASSOCIATES	Legal	185
STONE POGRUND & KOREY, LLC.	Legal	213
STONE POGRUND & KOREY, LLC.	Legal	1,122
STONE POGRUND & KOREY, LLC.	Legal	663
STONE POGRUND & KOREY, LLC.	Legal	990
STONE POGRUND & KOREY, LLC.	Legal	238
STONE POGRUND & KOREY, LLC.	Legal	500
STONE, MCGUIRE & SIEGAL	Legal	31
DEC 2013 LEGACY EXPENSE REIMBURSEMENT	Legal	2,350
LEGACY EXPENSE ALLOCATION - JUNE 2013	Legal	411
LEGACY EXPENSE REIMBURSEMENTS - NOV 2013	Legal	244
MARCH YTD LEGACY REIMBURSEMENT	Legal	34
MAY YTD LEGACY REIMBURSEMENT	Legal	1,636

OCTOBER 2013 REIMBURSEMENT	Legal	1,092
SEPT 2013 LEGACY REIMBURSEMENTS	Legal	5,177
TO BOOK ASHMAN & STEIN REIM B TO LEGACY	Legal	520

Total Legal, line 19, column 3 **41,027**

Consultants	Data Processing	16,800
Achieve Accreditation	Data Processing	11,858
FAY Esformes Interiors, Inc	Interior Design	1,500
Govig and Associates, Inc.	Staffing	17,000
IIT/Sourcetechn	Data Processing	1,815
Illinois Rytes Corp.	Regulatory Navigation	12,107
MTS Consulting LLC	Medical	7,870
Personnel Planners, Inc.	Staffing	1,481
Premier Medical Services, Inc.	Medical	12,357
Professional Search Network	Staffing	1,455
SAS Architects & Planners	Architecture	4,577
Legacy Reimbursements	Various	11,044

Schedule V, line 19, column 3 **140,889**

Allocation from Astoria Real Properties	16,120
Allocation from Legacy Healthcare	8,514
Allocation from Progressive Healthcare	327

Schedule V, line 19, column 8 **232,871**

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

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

Facility Name & ID Number Astoria Place Living & Rehab

0050799

Report Period Beginning: 01/01/13

Ending: 12/31/13

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. IL CLTC: \$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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,987 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. \$ 283,846
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?
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.