FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0050799

Facility Name: Astoria Place Living & Rehab

Address: 6300 N. California (Number) Chicago (City) 60659 (Zip Code)

County: Cook

Telephone Number: (773) 973-1900 **Fax #** (773) 973-1904

HFS ID Number:

Date of Initial License for Current Owners: 01/01/10

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	34,620	3,541	7,090	45,251	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,620	3,541	7,090	45,251	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.59%

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 [X] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

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 [X] Date 01/01/10 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 164 and days of care provided 5,881

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	281,962	26,326	9,312	317,600		317,600		317,600			1
2	Food Purchase		271,084		271,084		271,084	138	271,222			2
3	Housekeeping	159,865	20,421		180,286		180,286	1,023	181,309			3
4	Laundry	64,365	14,397		78,762		78,762		78,762			4
5	Heat and Other Utilities			201,313	201,313		201,313	3,206	204,519			5
6	Maintenance	65,875		93,902	159,777		159,777	4,672	164,449			6
7	Other (specify):*											7
8	TOTAL General Services	572,067	332,228	304,527	1,208,822		1,208,822	9,039	1,217,861			8
	B. Health Care and Programs											
9	Medical Director			43,200	43,200		43,200		43,200			9
10	Nursing and Medical Records	2,478,921	171,005	30,089	2,680,015		2,680,015	8,405	2,688,420			10
10a	Therapy			577,903	577,903		577,903		577,903			10a
11	Activities	102,823	7,166	2,604	112,593		112,593		112,593			11
12	Social Services	78,810		5,960	84,770		84,770		84,770			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,660,554	178,171	659,756	3,498,481		3,498,481	8,405	3,506,886			16
	C. General Administration											
17	Administrative	142,437	50,241	484,100	676,778		676,778	(447,040)	229,738			17
18	Directors Fees											18
19	Professional Services			116,612	116,612		116,612	2,916	119,528			19
20	Dues, Fees, Subscriptions & Promotions			17,955	17,955		17,955	2	17,957			20
21	Clerical & General Office Expenses	84,513		258,310	342,823		342,823	(117,076)	225,747			21
22	Employee Benefits & Payroll Taxes			607,405	607,405		607,405	19,463	626,868			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,885	2,885		2,885	(410)	2,475			24
25	Other Admin. Staff Transportation			13,907	13,907		13,907	639	14,546			25
26	Insurance-Prop.Liab.Malpractice			127,216	127,216		127,216	407	127,623			26
27	Other (specify):*											27
28	TOTAL General Administration	226,950	50,241	1,628,390	1,905,581		1,905,581	(541,099)	1,364,482			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,459,571	560,640	2,592,673	6,612,884		6,612,884	(523,655)	6,089,229			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							65,907	65,907			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			41,078	41,078		41,078	8,867	49,945			32
33	Real Estate Taxes			147,000	147,000		147,000	5,469	152,469			33
34	Rent-Facility & Grounds			733,285	733,285		733,285	(5,466)	727,819			34
35	Rent-Equipment & Vehicles			12,956	12,956		12,956	136	13,092			35
36	Other (specify):*											36
37	TOTAL Ownership			934,319	934,319		934,319	74,913	1,009,232			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			183,490	183,490		183,490		183,490			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):* Non-Allowable Cos			448,031	448,031		448,031	(448,031)				43
44	TOTAL Special Cost Centers			631,521	631,521		631,521	(448,031)	183,490			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,459,571	560,640	4,158,513	8,178,724		8,178,724	(896,773)	7,281,951			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	(30,804)	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	58,112	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,224)	43		18
19	Entertainment				19
20	Contributions	(59,026)	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				24
25	Fund Raising, Advertising and Promotional	(48,705)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,000)	43		28
29	Other-Attach Schedule See Pg 5A	(305,125)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (392,772)		$	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)	(504,001)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (504,001)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (896,773)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Astoria Place Living & Rehab

ID# 0050799

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicaid Tax	$ (89,790)	43	1
2	Lab & Radiology	(5,088)	43	2
3	Drugs	(15,255)	43	3
4	Patient pers. Items	(1,757)	43	4
5	Admitting	(13,040)	43	5
6	Professional Fees	(2,398)	19	6
7	Education & Seminars	(455)	24	7
8	Allowance for bad debts	(177,342)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46	SEE ACCOUNTANTS' COMPILATION REPORT			46
47				47
48				48
49	**Total**	(305,125)		49

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Chaim Rajchenbach	28	See Schedule 6A		See Schedule A		
Menachem Shabat	28					
Ronald Shabat	14					
Shari Borenstein	5					
Jamie Dlatt	5					
Howard Borenstein	5					

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

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%	$ 138	$ 138	1
2	V	3	Housekeeping Salaries		Legacy Healthcare Financial Services, LLC	100.00%	1,016	1,016	2
3	V	3	Housekeeping Supplies		Legacy Healthcare Financial Services, LLC	100.00%	7	7	3
4	V	5	Utilities		Legacy Healthcare Financial Services, LLC	100.00%	3,206	3,206	4
5	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services, LLC	100.00%	730	730	5
6	V	10	Nursing Salary		Legacy Healthcare Financial Services, LLC	100.00%	8,405	8,405	6
7	V	17	Administrative Salary - Mgmt Alloc	484,100	Legacy Healthcare Financial Services, LLC	100.00%	20,027	(464,073)	7
8	V	19	Other Professional Fees		Legacy Healthcare Financial Services, LLC	100.00%	2,142	2,142	8
9	V	19	Accounting		Legacy Healthcare Financial Services, LLC	100.00%	1,049	1,049	9
10	V	19	Legal Fees		Legacy Healthcare Financial Services, LLC	100.00%	2,123	2,123	10
11	V	19	Data Processing		Legacy Healthcare Financial Services, LLC	100.00%	79	79	11
12	V	20	Dues, Licenses, & Fees		Legacy Healthcare Financial Services, LLC	100.00%	2	2	12
13	V	21	Office Supplies		Legacy Healthcare Financial Services, LLC	100.00%	14,856	14,856	13
14	Total			$ 484,100			$ 53,780	$ * (430,320)	14

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

Provider Name: **Astoria Place Living & Rehab**
Provider #: **0050799**
Year End **12/31/2010**

Schedule 6A

Schedule V.A. Related Parties **Schedule 6A**

Related Nursing Homes			Related Nursing Homes			Other Related Business Entities		
Owners	**Name**	**City**	**Owners**	**Name**	**City**	**Name**	**City**	**Type of Business**
Chaim Rajchenbach	Grove Lincoln Park Living & Rehab Center	Chicago	Ronald Shabat	The Grove of LaGrange Park	LaGrange Park	Legacy Healthcare Financial Services, LLC	Skokie	Management Company
	Pine Acres Rehab & Living Center	DeKalb		Florence Nursing Home	Marengo	Legacy Real Properties, LLC	Skokie	Real Estate
	Astoria Place Living & Rehab	Chicago		The Fountain's	Marion	Grove Healthcare Properties, LLC	Skokie	Real Estate
	The Grove of Evanston	Evanston		Friendship Care Center - Herrin	Herrin	Shabat & Associates, LLC	Chicago	Management Company
	Grove North Living & Rehab Center	Chicago		City Care Center of Cobden	Cobden	JLR Management	Chicago	Management Company
	Elmbrook Nursing	Elmbrook		Grove Lincoln Park Living & Rehab Center	Chicago			
	The Grove of LaGrange Park	LaGrange Park		Peterson Park Health Care Center	Chicago			
				Ridgeway Manor	Ridgeway			
Menachem Shabat	Lakefront Nursing & Rehab Center	Chicago		Sheridan Health Care Center	Zion			
	Grove Lincoln Park Living & Rehab Center	Chicago		Oak Grove Rehab & Skilled Care	Carbondale			
	Astoria Place Living & Rehab	Chicago		Astoria Place Living & Rehab	Chicago			
	The Grove of Evanston	Evanston		The Grove of Evanston	Evanston			
	Grove North Living & Rehab Center	Chicago		Grove North Living & Rehab Center	Chicago			
	The Grove of LaGrange Park	LaGrange Park		Elmbrook Nursing	Elmbrook			
	Elmbrook Nursing	Elmbrook						

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 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)	
15	V	21	Clerical Salaries	$ 210,000	Legacy Healthcare Financial Services, LLC	100.00%	$ 92,845	$ (117,155)	15
16	V	24	Travel		Legacy Healthcare Financial Services, LLC	100.00%	639	639	16
17	V	25	Education & Seminars		Legacy Healthcare Financial Services, LLC	100.00%	45	45	17
18	V	26	Insurance Expense		Legacy Healthcare Financial Services, LLC	100.00%	407	407	18
19	V	27	Employee Benefits - Mgmt Alloc		Legacy Healthcare Financial Services, LLC	100.00%	19,463	19,463	19
20	V	30	Depreciation Expense		Legacy Healthcare Financial Services, LLC	100.00%	774	774	20
21	V	32	Amortization Expense		Legacy Healthcare Financial Services, LLC	100.00%	271	271	21
22	V	33	Real Estate Taxes		Legacy Healthcare Financial Services, LLC	100.00%	5,469	5,469	22
23	V	34	Rent Expense		Legacy Healthcare Financial Services, LLC	100.00%	32,091	32,091	23
24	V	35	Equipment Rental		Legacy Healthcare Financial Services, LLC	100.00%	136	136	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			$ 210,000			$ 152,140	$ * (57,860)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 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)	
15	V	6	Repairs & Maintenance	$	Legacy Real Properties, LLC	100.00%	$ 3,942	$ 3,942	15
16	V	21	Office Expense		Legacy Real Properties, LLC	100.00%	2,177	2,177	16
17	V	30	Depreciation		Legacy Real Properties, LLC	100.00%	7,021	7,021	17
18	V	32	Interest		Legacy Real Properties, LLC	100.00%	8,596	8,596	18
19	V	33	Real Estate Taxes	6,049	Legacy Real Properties, LLC	100.00%	6,049		19
20	V	34	Rent	37,557	Legacy Real Properties, LLC	100.00%		(37,557)	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			$ 43,606			$ 27,785	$ * (15,821)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Chaim Rajchenbach	Owner	Administrative	29.00	168,560	7	14.90	Mgmt. Salary	$ 27,440	17(1)	1
2	Menachem Shabat	Owner	Administrative	29.00	171,671	7	14.90	Mgmt. Salary	24,329	17(1)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 51,769		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: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	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	2	Dietary	Patient Days	304,581	10	$ 926	$	45,251	$ 138	1
2	3	Housekeeping Salaries	Patient Days	304,581	10	6,838	6,838	45,251	1,016	2
3	3	Housekeeping Supplies	Patient Days	304,581	10	46		45,251	7	3
4	5	Utilities	Patient Days	304,581	10	21,580		45,251	3,206	4
5	6	Repairs & Maintenance	Patient Days	304,581	10	4,917		45,251	730	5
6	10	Nursing Salary	Patient Days	304,581	10	56,573		45,251	8,405	6
7	17	Administrative Salary - Mgmt Allo	Patient Days	304,581	10	134,800	134,800	45,251	20,027	7
8	19	Other Professional Fees	Patient Days	304,581	10	14,420		45,251	2,142	8
9	19	Accounting	Patient Days	304,581	10	7,058		45,251	1,049	9
10	19	Legal Fees	Patient Days	304,581	10	14,289		45,251	2,123	10
11	19	Data Processing	Patient Days	304,581	10	531		45,251	79	11
12	20	Dues, Licenses, & Fees	Patient Days	304,581	10	15		45,251	2	12
13	21	Office Supplies	Patient Days	304,581	10	99,999		45,251	14,856	13
14	21	Clerical Salaries	Patient Days	304,581	10	624,930	624,930	45,251	92,845	14
15	24	Travel	Patient Days	304,581	10	4,300		45,251	639	15
16	25	Education & Seminars	Patient Days	304,581	10	300		45,251	45	16
17	26	Insurance Expense	Patient Days	304,581	10	2,741		45,251	407	17
18	27	Employee Benefits - Mgmt Alloc	Patient Days	304,581	10	131,010		45,251	19,463	18
19	30	Depreciation Expense	Bed Days Available	363,747	10	4,701		59,860	774	19
20	32	Amortization Expense	Patient Days	304,581	10	1,827		45,251	271	20
21	33	Real Estate Taxes	Patient Days	304,581	10	36,809		45,251	5,469	21
22	34	Rent Expense	Patient Days	304,581	10	216,000		45,251	32,091	22
23	35	Equipment Rental	Patient Days	304,581	10	917		45,251	136	23
24										24
25	TOTALS					$ 1,385,527	$ 766,568		$ 205,920	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	The Private Bank		X	Back up CD	$1,008.33	03/03/10	$ 500,000	$ 500,000	02/02/11	0.0220	$ 9,350	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit	$1,418.96	03/03/10		207,531		0.0600	30,256	6
7												7
8												8
9	TOTAL Facility Related				$2,427.29		$ 500,000	$ 707,531			$ 39,606	9
	B. Non-Facility Related*											
10								Allocation from management			8,867	10
11								Interest on Insurance Financing			266	11
12								Interest Due from Grove HC Prop.			1,206	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 10,339	14
15	TOTALS (line 9+line14)						$ 500,000	$ 707,531			$ 49,945	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 147,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		$	5
	Allocation from Mgmt.	5,469	
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.		$ 152,469	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

N/A

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Astoria Place Living & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050799

CONTACT PERSON REGARDING THIS REPORT Michael Navarro

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 01/01/2010 Ending: 12/31/2010

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 [X] (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? [X] (a) Own the Equipment [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from Legacy Real Properties			$ 13,419	1
2					2
3	TOTALS			$ 13,419	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated from Legacy Real Properties				$ 103,953	$		$ 3,465	$ 3,465	$ 5,199	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Door System and Locks			2010	6,590		10	329	329	329	9
10	Roofing			2010	10,125		10	506	506	506	10
11	Landscape Irrigation System			2010	6,500		10	325	325	325	11
12	Resident Room Built-in Furniture			2010	84,920		15	2,831	2,831	2,831	12
13	Office Furniture			2010	6,071		15	202	202	202	13
14	Carpeting			2010	15,513		5	1,551	1,551	1,551	14
15	Fire Alarm System			2010	19,877		10	994	994	994	15
16	Electrical			2010	17,930		20	448	448	448	16
17	Admin Bathroom			2010	8,450		20	211	211	211	17
18	Millwork			2010	59,488		15	1,983	1,983	1,983	18
19	Painting and drywall			2010	16,878		5	1,688	1,688	1,688	19
20	Waterfountain			2010	1,275		10	64	64	64	20
21	Improvements			2010	26,520		20	663	663	663	21
22	Therapy Room Remodel			2010	10,375		20	259	259	259	22
23	Plumbing			2010	23,585		20	590	590	590	23
24	Tile and Installation			2010	40,616		10	2,031	2,031	2,031	24
25	Grease Trap			2010	14,150		10	708	708	708	25
26	Phone System			2010	7,000		10	350	350	350	26
27	Elevator			2010	3,874		20	97	97	97	27
28	Windows			2010	209,850		20	5,246	5,246	5,246	28
29	1st Floor Rehab			2010	111,411		20	2,785	2,785	2,785	29
30	Satellite			2010	12,500		10	625	625	625	30
31	PT Room			2010	13,247		10	662	662	662	31
32	Window Drapes			2010	31,707		5	3,171	3,171	3,171	32
33	Resident Room & Rehab			2010	56,575		20	1,414	1,414	1,414	33
34	Electronic			2010	16,265		20	407	407	407	34
35	Family Dining			2010	7,000		20	175	175	175	35
36	Rehab Bathrooms			2010	7,808		10	390	390	390	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Wall covering	2010	$ 14,943	$	5	$ 1,494	$ 1,494	$ 1,494	37
38	Signs	2010	24,203		10	1,210	1,210	1,210	38
39	Light Fixtures	2010	7,475		10	374	374	374	39
40	Window Guards	2010	3,800		20	95	95	95	40
41	New Fence	2010	23,922		15	797	797	797	41
42	Library	2010	36,204		20	905	905	905	42
43	Tuckpointing	2010	7,315		20	183	183	183	43
44	Architectural Design	2010	1,237		10	62	62	62	44
45	Nurses Station	2010	14,000		15	467	467	467	45
46	New Fire Pump	2010	4,236		20	106	106	106	46
47	Entrance Rehab	2010	37,684		10	1,884	1,884	1,884	47
48	2nd Floor Rehab	2010	17,171		20	429	429	429	48
49	Parking Lot	2010	5,491		10	275	275	275	49
50	Landscaping	2010	28,850		10	1,443	1,443	1,443	50
51									51
52									52
53									53
54									54
55	Allocated from Legacy Real Properties		76,986			1,834	1,834	2,573	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,253,570	$		$ 45,728	$ 45,728	$ 48,201	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$	$	$	$		$	71
72	Current Year Purchases	179,008		17,687	17,687	3-7 Yrs	17,687	72
73	Fully Depreciated Assets							73
74	See Attached Schedule 13A	31,084		2,492	2,492		3,230	74
75	TOTALS	$ 210,092	$	$ 20,179	$ 20,179		$ 20,917	75

D. Vehicle Depreciation (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)	$ 1,477,081	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 65,907	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 65,907	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 69,118	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
FYE: 12/31/2010
Schedule 13A

	Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciatio	Adjustmen	Component Life	Accumulated Depreciation
1	Allocation from LHFS, Inc	4,016		774	774	5	1,146
2	Allocated from Legacy Real Properties	27,068		1,718	1,718	5	2,084
	Totals	31,084		2,492	2,492		3,230

See Accountants' Compilation Report

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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:	1976	164	01/01/2010	$ 359,160			3
4	Additions			07/01/2010	374,125			4
5	Allocated from LHFS, LLC				32,091			5
6	Allocated from Legacy Real Properties, LLC				(37,557)			6
7	TOTAL		164		$ 727,819 **			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: N/A *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 13,092 Description: Beds/chair/mattress - $12,062; Postage Machine - $894; Allocation from HO - $136
(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	N/A		$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	L10A, C3	hrs	$	12,321	$ 331,836	$	12,321	$ 331,836	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		4,817	54,777		4,817	54,777	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		16,472	191,290		16,472	191,290	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	33,610	$ 577,903	$	33,610	$ 577,903	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 502,642	$ 502,642	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	1,106,924	1,106,924	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,939	11,939	6
7	Other Prepaid Expenses	1,053	1,053	7
8	Accounts Receivable (owners or related parties)	2,098	2,098	8
9	Other(specify): See Attached Sch 17A	671,785	671,785	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,296,441	$ 2,296,441	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		13,419	13
14	Buildings, at Historical Cost		103,953	14
15	Leasehold Improvements, at Historical Cost		1,149,617	15
16	Equipment, at Historical Cost		210,092	16
17	Accumulated Depreciation (book methods)		(69,118)	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)**	$	$ 1,407,963	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,296,441	$ 3,704,404	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 477,073	$ 477,073	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	310,044	310,044	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	147,000	147,000	32
33	Accrued Interest Payable	2,427	2,427	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Sch 17A	173,528	173,528	36
37	Other Current Liabilities	1,104	1,104	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,111,176	$ 1,111,176	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	707,531	707,531	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 707,531	$ 707,531	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,818,707	$ 1,818,707	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 477,734	$ 1,885,697	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,296,441	$ 3,704,404	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Astoria Place Living and Rehab
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Schedule 17A

Line 9	Operating	After Consolidation
Security Deposits	2,587	2,587
Due to Medicare	274,701	274,701
Leg Charity	3,174	3,174
Lincoln Park	(995)	(995)
AHCP	392,318	392,318
Total	671,785	671,785

Line 36	Operating	After Consolidation
Refund-Transfer	1,797	1,797
Accrued MGMT Fee	158,592	158,592
Accrued FICA	11,933	11,933
T/F GHCP	1,206	1,206
Total	173,528	173,528

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			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)	477,734	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 477,734	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)**	$ 477,734	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,246,795	1
2	Discounts and Allowances for all Levels	233,959	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,480,754	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	978,191	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 978,191	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	181,419	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	13,452	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 194,871	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,642	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,642	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue		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)**	$ 8,656,458	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,208,822	31
32	Health Care	3,498,481	32
33	General Administration	1,905,581	33
	B. Capital Expense		
34	Ownership	934,319	34
	C. Ancillary Expense		
35	Special Cost Centers	631,521	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,178,724	40
41	**Income before Income Taxes (line 30 minus line 40)****	477,734	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 477,734	43

***** 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.
**LLC members are cash basis tax payers

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

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

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,008	2,452	$ 109,798	$ 44.78	1
2	Assistant Director of Nursing	1,376	1,408	45,180	32.09	2
3	Registered Nurses	29,200	33,412	1,018,664	30.49	3
4	Licensed Practical Nurses	7,303	7,974	190,826	23.93	4
5	CNAs & Orderlies	70,603	76,104	1,012,961	13.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,898	2,189	34,121	15.59	9
10	Activity Assistants	7,252	7,711	68,702	8.91	10
11	Social Service Workers	4,648	4,907	78,810	16.06	11
12	Dietician	1,992	2,209	49,659	22.48	12
13	Food Service Supervisor					13
14	Head Cook	381	381	4,484	11.77	14
15	Cook Helpers/Assistants	17,923	19,960	227,819	11.41	15
16	Dishwashers					16
17	Maintenance Workers	3,953	4,139	65,875	15.92	17
18	Housekeepers	13,870	15,294	159,865	10.45	18
19	Laundry	5,311	5,673	64,365	11.35	19
20	Administrator	2,392	2,440	74,998	30.74	20
21	Assistant Administrator	4,016	4,474	67,439	15.07	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,811	7,616	84,513	11.10	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)	2,952	3,159	85,556	27.08	30
31	Medical Records	1,840	2,037	15,936	7.82	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	185,729	203,539	$ 3,459,571 *	$ 17.00	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	186	$ 9,312	1(3)	35
36	Medical Director	Monthly	43,200	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	6,750	10(3)	38
39	Pharmacist Consultant	Monthly	6,004	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	46	2,576	11(3)	44
45	Social Service Consultant	103	5,960	12(3)	45
46	Other(specify) MDS	Monthly	11,943	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	335	$ 85,745		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	45	1,612	10(3)	51
52	Certified Nurse Assistants/Aides	128	2,632	10(3)	52
53	TOTAL (lines 50 - 52)	173	$ 4,244		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mordechai Polstein	Administrator	100	$ 142,437
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 142,437

B. Administrative - Other

Description	Amount
Management Fees	$ 484,100
Eliminated on Sch V Col 7	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 484,100
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RSM McGladrey	Accounting	$ 16,090
Stephen N. Sher PC	Legal	27,100
Much Shelist	Legal	2,869
Skidelsky & Associates	Legal	5,340
Scott & Krause	Legal	16,763
See Sch21A	Various	48,450
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 116,612

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,086
Unemployment Compensation Insurance	63,645
FICA Taxes	267,074
Employee Health Insurance	167,269
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	394
Union Pension	23,651
Uniforms	19,286
Allocation from Legacy Healthcare	19,463
TOTAL (agree to Schedule V, line 22, col.8)	$ 626,868

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,764
Advertising: Employee Recruitment	125
Health Care Worker Background Check	
(Indicate # of checks performed 691)	8,290
Patient Background Checks	
Miscellaneous Licenses & Fees	2,775
Miscellaneous Dues	1,196
IL Council on Long Term Care Dues	805
Allocation from Legacy Healthcare	2
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,957

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,430
Allocation from Legacy Healthcare	45
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,475

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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Schedule 21A - Other Professional Fees

Vendor	Type	Amount
RSM McGladrey	Accounting	750
Meyer Magence	Legal	3,438
ML Enterprises	Purchasing	3,550
Tohtz Consulting, Inc	Software	40
Rabbi Mel Lifsics	Religious	8,500
IIT/Sourcetech	Dietary	630
Personnel Planners, Inc.	Unemployment	810
Singer Networks, LLC	Computer	13,546
CES Consulting of IL	Human Resource	579
Govig & Associates	Recruitment	24,000
Moshe Calamaro & Associates	Engineering	460
Premier Medical Services	Recruitment	2,000
Madison Specs	Engineering	4,200
First Real Estate Services	Appraisal	2,750
Journal entry per client WP		2,398
Rounding		(1)
Subtotal		**67,650**
Less adjustments per client WP		(19,200)
Schedule V, line 19, column 3		**48,450**
Add amount from RE entity		2,142
Less unsupported Journal Entry per client		(2,398)
Less amount reclassed to legal		(3,438)
Less amount reclassed to accounting		(750)
Other Professional on line 19, column 8		**44,006**

Accounting Fees in line 19, column 3	16,090
Reclass to accounting	750
Allocation from Legacy Healthcare	1,049
Accounting Fees in line 19, column 8	17,889
Legal Fees in line 19, column 3	52,072
Reclass to legal	3,438
Allocation from Legacy Healthcare	2,123
Legal Fees in line 19, column 8	57,633
Other professional Fees in line 19, column 8	44,006
Total Fees in Line 19, Column 8	119,528

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Astoria Place Living & Rehab # 0050799 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. **Illinois Council on Long Term Care - $805**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,346** 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. $ **0**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

SEE ACCOUNTANTS' COMPILATION REPORT