		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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053900

Facility Name: Astoria Place

Address: 6300 N. California Ave. (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: 1/1/2010

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/17 to 12/31/17 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) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	44,195	4,776	6,957	55,928	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,195	4,776	6,957	55,928	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.43%

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

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

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

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

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 1/1/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2010 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 5,644

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	421,674	35,350	8,954	465,978		465,978		465,978			1
2	Food Purchase		461,917		461,917		461,917	(15,600)	446,317			2
3	Housekeeping	249,125	47,395	91	296,611		296,611	218	296,829			3
4	Laundry	40,788	21,283		62,071		62,071	6	62,077			4
5	Heat and Other Utilities			274,506	274,506		274,506	(7,894)	266,612			5
6	Maintenance	89,315	19,253	155,879	264,447		264,447	72,309	336,756			6
7	Other (specify):*											7
8	**TOTAL General Services**	800,902	585,198	439,430	1,825,530		1,825,530	49,039	1,874,569			8
	B. Health Care and Programs											
9	Medical Director			38,024	38,024		38,024	669	38,693			9
10	Nursing and Medical Records	3,329,371	83,264	35,677	3,448,312		3,448,312	108,759	3,557,071			10
10a	Therapy	230,350			230,350		230,350		230,350			10a
11	Activities	131,940	6,654	596	139,190		139,190	5,085	144,275			11
12	Social Services	262,518		11,282	273,800		273,800	1,826	275,626			12
13	CNA Training											13
14	Program Transportation			22,573	22,573		22,573		22,573			14
15	Other (specify):*							17,450	17,450			15
16	**TOTAL Health Care and Programs**	3,954,179	89,918	108,152	4,152,249		4,152,249	133,788	4,286,037			16
	C. General Administration											
17	Administrative	103,664			103,664		103,664	174,843	278,507			17
18	Directors Fees											18
19	Professional Services			116,070	116,070	(234)	115,836	(2,216)	113,620			19
20	Dues, Fees, Subscriptions & Promotions			72,606	72,606		72,606	(25,916)	46,690			20
21	Clerical & General Office Expenses	170,975	3,256	453,535	627,766		627,766	(179,732)	448,034			21
22	Employee Benefits & Payroll Taxes			795,585	795,585		795,585		795,585			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,752	2,752		2,752	2,017	4,769			24
25	Other Admin. Staff Transportation			909	909		909		909			25
26	Insurance-Prop.Liab.Malpractice			165,087	165,087		165,087	3,718	168,805			26
27	Other (specify):*							73,180	73,180			27
28	**TOTAL General Administration**	274,639	3,256	1,606,544	1,884,439	(234)	1,884,205	45,893	1,930,099			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,029,720	678,372	2,154,126	7,862,218	(234)	7,861,984	228,721	8,090,705			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 #0053900 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			83,381	83,381		83,381	534,934	618,315			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,206	77,206		77,206	1,337,162	1,414,368			32
33	Real Estate Taxes			233,004	233,004	234	233,238	4,708	237,945			33
34	Rent-Facility & Grounds			2,733,143	2,733,143		2,733,143	(2,723,383)	9,760			34
35	Rent-Equipment & Vehicles			15,048	15,048		15,048	4,630	19,678			35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,141,782	3,141,782	234	3,142,016	(841,950)	2,300,066			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		371,197	1,029,817	1,401,014		1,401,014		1,401,014			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			397,188	397,188		397,188		397,188			42
43	Other (specify):*			708,090	708,090		708,090	(708,090)	(0)			43
44	**TOTAL Special Cost Centers**		371,197	2,135,095	2,506,292		2,506,292	(708,090)	1,798,202			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,029,720	1,049,569	7,431,003	13,510,292		13,510,292	(1,321,319)	12,188,973			45

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(9,165)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	534,090	30		9
10	Interest and Other Investment Income	(11,146)	32		10
11	Discounts, Allowances, Rebates & Refunds	(15,274)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(394)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,130)	21		18
19	Entertainment	(2,084)	21		19
20	Contributions	(245)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(254,124)	21		24
25	Fund Raising, Advertising and Promotional	(16,039)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,394,703)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,172,214)		$	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)	(149,105)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (149,105)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,321,319)		37

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

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

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

Astoria Place

ID# 0053900

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Personal Items	$ (1,873)	10	1
2	Sequestration Expense	(79,579)	21	2
3	Pharmacy Discounts	(1,392)	10	3
4	Miscellaneous Income	(22,993)	21	4
5	Additional R&M	21,918	06	5
6	PAC Dues	(10,711)	20	6
7	Non-Allowable Legal Fees	(12,108)	19	7
8	Bldg Co - Tax Extension Fee	(2,000)	19	8
9	Bldg Co - Filing Fees	(250)	19	9
10	Bldg Co - Title Fees	(4,630)	20	10
11	Bldg Co - Professional Fees - Accounting	(4,255)	19	11
12	Bldg Co - Professional Fees - Legal	(15,175)	19	12
13	Bldg Co - Loan Fee	(81,038)	36	13
14	Bldg Co - Management Fee	(439,510)	21	14
15	Non-Allowable Expense	(708,090)	43	15
16	Bank Charges	(33,018)	21	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,394,703)		49

Astoria Place

ID# 0053900

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Astoria Place # 0053900 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(15,668)		49	19								(15,600)	2
3	Housekeeping			218									218	3
4	Laundry			6									6	4
5	Heat and Other Utilities	(9,165)				1,271							(7,894)	5
6	Maintenance	21,918		2,943	45,841	1,607							72,309	6
7	Other (specify):*													7
8	**TOTAL General Services**	(2,915)		3,216	45,860	2,879							49,039	8
	B. Health Care and Programs													
9	Medical Director			669									669	9
10	Nursing and Medical Records	(3,265)		41	112,286		(303)						108,759	10
10a	Therapy													10a
11	Activities			5,065	19								5,085	11
12	Social Services			80	1,746								1,826	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				17,450								17,450	15
16	**TOTAL Health Care and Programs**	(3,265)		5,856	131,501		(303)						133,788	16
	C. General Administration													
17	Administrative			23,026	151,817								174,843	17
18	Directors Fees													18
19	Professional Services	(33,788)	21,679	15,643	383	320			(6,454)				(2,216)	19
20	Fees, Subscriptions & Promotions	(31,625)	4,630	890	187	3							(25,916)	20
21	Clerical & General Office Expenses	(834,438)	439,510	182,674	32,521	1							(179,732)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,176	841								2,017	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			986	2,402	329							3,718	26
27	Other (specify):*			37,483	35,696								73,180	27
28	**TOTAL General Administration**	(899,850)	465,819	261,878	223,848	652			(6,454)				45,893	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(906,030)	465,819	270,950	401,208	3,531	(303)		(6,454)				228,721	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Astoria Place** **#** **0053900** **Report Period Beginning:** **01/01/17** **Ending:** **12/31/17**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	**534,090**			**844**								**534,934**	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	**(11,146)**	**1,342,546**	**19**		**5,744**							**1,337,162**	32
33	Real Estate Taxes					**4,708**							**4,708**	33
34	Rent-Facility & Grounds		**(2,723,543)**	**45,581**	**65**	**(45,486)**							**(2,723,383)**	34
35	Rent-Equipment & Vehicles			**3,338**	**1,292**								**4,630**	35
36	Other (specify):*	**(81,038)**	**81,038**											36
37	**TOTAL Ownership**	**441,906**	**(1,299,960)**	**48,937**	**2,202**	**(35,034)**							**(841,950)**	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	**(708,090)**											**(708,090)**	43
44	**TOTAL Special Cost Centers**	**(708,090)**											**(708,090)**	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(1,172,214)**	**(834,140)**	**319,887**	**403,409**	**(31,503)**	**(303)**		**(6,454)**				**(1,321,319)**	45

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	34	Rent	$ 2,723,543	Astoria HC Properties	100.00%	$	$ (2,723,543)	1
2	V	32	Interest		Astoria HC Properties	100.00%	1,342,546	1,342,546	2
3	V	19	Tax Extension Fee		Astoria HC Properties	100.00%	2,000	2,000	3
4	V	19	Filing Fees		Astoria HC Properties	100.00%	250	250	4
5	V	20	Title Fees		Astoria HC Properties	100.00%	4,630	4,630	5
6	V	19	Professional Fees - Accounting		Astoria HC Properties	100.00%	4,255	4,255	6
7	V	19	Professional Fees - Legal		Astoria HC Properties	100.00%	15,175	15,175	7
8	V	36	Loan Fee		Astoria HC Properties	100.00%	81,038	81,038	8
9	V	21	Management Fee		Astoria HC Properties	100.00%	439,510	439,510	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,723,543			$ 1,889,403	$ * (834,140)	14

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2	FOOD	$	Legacy Healthcare Financial Services	100.00%	$ 49	$ 49	15
16	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	218	218	16
17	V	4	LINEN REPLACEMENT		Legacy Healthcare Financial Services	100.00%	6	6	17
18	V	6	UTILITIES		Legacy Healthcare Financial Services	100.00%	12	12	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	2,931	2,931	19
20	V	9	MEDICAL DIRECTOR CONSULTANT		Legacy Healthcare Financial Services	100.00%	669	669	20
21	V	10	MEDICAL SUPPLIES		Legacy Healthcare Financial Services	100.00%	41	41	21
22	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	5,065	5,065	22
23	V	12	SOCIAL SERVICE CONSULTANT		Legacy Healthcare Financial Services	100.00%	80	80	23
24	V	17	ADMINISTRATIVE SALARY		Legacy Healthcare Financial Services	100.00%	23,026	23,026	24
25	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	15,643	15,643	25
26	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	890	890	26
27	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	177,762	177,762	27
28	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	4,912	4,912	28
29	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	1,176	1,176	29
30	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	986	986	30
31	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	37,483	37,483	31
32	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	19	19	32
33	V	34	RENT		Legacy Healthcare Financial Services	100.00%	45,486	45,486	33
34	V	34	STORAGE		Legacy Healthcare Financial Services	100.00%	95	95	34
35	V	35	EQUIPMENT RENTAL		Legacy Healthcare Financial Services	100.00%	23	23	35
36	V	35	AUTO RENTAL		Legacy Healthcare Financial Services	100.00%	3,314	3,314	36
37	V								37
38	V								38
39	Total			$			$ 319,887	$ * 319,887	39

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2	FOOD	$	Progressive Healthcare Consulting	100.00%	$ 19	$ 19	15
16	V	6	MAINTENANCE SALARY		Progressive Healthcare Consulting	100.00%	45,704	45,704	16
17	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	136	136	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	112,286	112,286	18
19	V	11	ACTIVITIES PROGRAM		Progressive Healthcare Consulting	100.00%	19	19	19
20	V	12	CLERGY CONSULTANT		Progressive Healthcare Consulting	100.00%	1,742	1,742	20
21	V	12	SOCIAL SERVICE		Progressive Healthcare Consulting	100.00%	4	4	21
22	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	17,450	17,450	22
23	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	151,817	151,817	23
24	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	383	383	24
25	V	20	DUES, SUBSCRIPTIONS, LICENSES		Progressive Healthcare Consulting	100.00%	187	187	25
26	V	21	CLERICAL WAGES		Progressive Healthcare Consulting	100.00%	32,177	32,177	26
27	V	21	CLERICAL & GENERAL - OTHER		Progressive Healthcare Consulting	100.00%	343	343	27
28	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	841	841	28
29	V	27	EMP. BEN.-NON-NURSING		Progressive Healthcare Consulting	100.00%	35,696	35,696	29
30	V	26	INSURANCE		Progressive Healthcare Consulting	100.00%	2,402	2,402	30
31	V	30	DEPRECIATION		Progressive Healthcare Consulting	100.00%	844	844	31
32	V	34	STORAGE RENTAL		Progressive Healthcare Consulting	100.00%	65	65	32
33	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	1,292	1,292	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 403,409	$ * 403,409	39

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	5	UTILITIES	$	CF ST. LOUIS, LLC	100.00%	$ 1,271	$ 1,271	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100.00%	1,607	1,607	16
17	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100.00%	320	320	17
18	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100.00%	3	3	18
19	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100.00%	1	1	19
20	V	26	INSURANCE		CF ST. LOUIS, LLC	100.00%	329	329	20
21	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100.00%	5,744	5,744	21
22	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100.00%	4,708	4,708	22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	45,486	CF ST. LOUIS, LLC	100.00%		(45,486)	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			$ 45,486			$ 13,982	$ * (31,503)	39

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	10	Medical Supplies	$ 7,454	ReMED Services		$ 7,151	$ (303)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,454			$ 7,151	$ * (303)	39

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	06	Maintenance	$ 17,100	ML Group Design and Development		$ 17,100	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 17,100			$ 17,100	$ *	39

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	19	Payroll Services	$ 26,891	ProPay HR LLC	24.00%	$ 20,437	$ (6,454)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 26,891			$ 20,437	$ * (6,454)	39

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN Family Trust	50.00%	AVANTARA LONG GROVE	LONG GROVE	ASTORIA REAL PROPERTIES		BUILDING COMPANY	1
2	Doros Generation Trust	50.00%	AVANTARA PARK RIDGE	PARK RIDGE	LEGACY HC & FINANCIAL SER	LINCOLNWOOD	HOME OFFICE/BOOKKEEPI	2
3			AZRIA MIDTOWN	OMAHA, NE	PROGRESSIVE HC	LINCOLNWOOD	NURSE CONSULTANT	3
4			AZRIA MONTCLAIR	OMAHA, NE	ML GROUP DESIGN & DEV	SKOKIE	ASSET MANAGEMENT	4
5			AZRIA OLATHE	OLATHE, KS	REMED SERVICES LLC	LINCOLNWOOD	NURSING EQUIPMENT	5
6			BETHANY TERRACE	MORTON GROVE	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	6
7			CARLTON SKILLED NURSING FACILITY LLC	CHICAGO	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	7
8			CEDAR SKILLED NURSING FACILITY	CEDAR CITY, UT	LINCOLNSHIRE ASSISTED LIVI	LINCOLNSHIRE	ASSISTED LIVING	8
9			CHALET SKILLED NURSING FACILITY LLC	CHICAGO	CF ST. LOUIS LLC	SKOKIE	BUILDING COMPANY	9
10			CLARK SKILLED NURSING FACILITY	CHICAGO	PROPAY HR	EVANSTON	PAYROLL PROCESSING	10
11			ELMBROOK SKILLED NURSING FACILITY LLC	ELMHURST				11
12			EVANSTON SKILLED NURSING FACILITY LLC	EVANSTON				12
13			GROVE AT THE LAKE SKILLED NURSING FACILITY LLC	ZION				13
14			GROVE OF FOX VALLEY	AURORA				14
15			LAGRANGE SKILLED NURSING FACILITY LLC	LAGRANGE PARK				15
16			LAKEFRONT SKILLED NURSING FACILITY LLC	CHICAGO				16
17			LINCOLN PARK SKILLED NURSING FACILITY LLC	CHICAGO				17
18			LINCOLNSHIRE LIVING & REHAB CENTER LLC	LINCOLNSHIRE				18
19			NORTHBROOK SKILLED NURSING FACILITY LLC	NORTHBROOK				19
20			PARKER SKILLED NURSING FACILITY LLC	PARKER, CO				20
21			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				21
22			SKOKIE SKILLED NURSING FACILITY LLC	SKOKIE				22
23			ST. GEORGE SKILLED NURSING FACILITY	ST. GEORGE, UT				23
24			WARREN BARR LIVING AND REHAB	CHICAGO				24
25			WARREN BARR NORTH SHORE	HIGHLAND PARK				25
26			WARREN BARR SOUTH LOOP	CHICAGO				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	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	FOOD	AVAIL. BED DAYS	1,789,215	30	$ 1,460	$	59,860	$ 49	1
2	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,789,215	30	6,519		59,860	218	2
3	4	LINEN REPLACEMENT	AVAIL. BED DAYS	1,789,215	30	171		59,860	6	3
4	6	UTILITIES	AVAIL. BED DAYS	1,789,215	30	372		59,860	12	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	87,596		59,860	2,931	5
6	9	MEDICAL DIRECTOR CONSU	AVAIL. BED DAYS	1,789,215	30	20,000		59,860	669	6
7	10	MEDICAL SUPPLIES	AVAIL. BED DAYS	1,789,215	30	1,237		59,860	41	7
8	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,789,215	30	151,405		59,860	5,065	8
9	12	SOCIAL SERVICE CONSULTA	AVAIL. BED DAYS	1,789,215	30	2,392		59,860	80	9
10	17	ADMINISTRATIVE SALARY	AVAIL. BED DAYS	1,789,215	30	688,242	688,242	59,860	23,026	10
11	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	467,580		59,860	15,643	11
12	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	26,590		59,860	890	12
13	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	1,789,215	30	5,313,296	5,313,296	59,860	177,762	13
14	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,789,215	30	146,833		59,860	4,912	14
15	24	SEMINARS	AVAIL. BED DAYS	1,789,215	30	35,138		59,860	1,176	15
16	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	29,475		59,860	986	16
17	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,789,215	30	1,120,380		59,860	37,483	17
18	32	INTEREST	AVAIL. BED DAYS	1,789,215	30	561		59,860	19	18
19	34	RENT	AVAIL. BED DAYS	1,789,215	30	1,359,562		59,860	45,486	19
20	34	STORAGE	AVAIL. BED DAYS	1,789,215	30	2,842		59,860	95	20
21	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	1,789,215	30	694		59,860	23	21
22	35	AUTO RENTAL	AVAIL. BED DAYS	1,789,215	30	99,069		59,860	3,314	22
23										23
24										24
25	TOTALS					$ 9,561,416	$ 6,001,539		$ 319,887	25

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: Progressive Healthcare Consulting
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	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	FOOD	AVAIL. BED DAYS	1,374,590	21	$ 432	$	59,860	$ 19	1
2	6	MAINTENANCE SALARY	AVAIL. BED DAYS	1,374,590	21	1,049,531	1,049,531	59,860	45,704	2
3	6	BUILDING MAINTENANCE AI	AVAIL. BED DAYS	1,374,590	21	3,133		59,860	136	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	1,374,590	21	2,578,462	2,578,462	59,860	112,286	4
5	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,374,590	21	443		59,860	19	5
6	12	CLERGY CONSULTANT	AVAIL. BED DAYS	1,374,590	21	39,998		59,860	1,742	6
7	12	SOCIAL SERVICE	AVAIL. BED DAYS	1,374,590	21	95		59,860	4	7
8	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	1,374,590	21	400,703		59,860	17,450	8
9	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	1,374,590	21	3,486,246	3,486,246	59,860	151,817	9
10	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,374,590	21	8,800		59,860	383	10
11	20	DUES, SUBSCRIPTIONS, LICE	AVAIL. BED DAYS	1,374,590	21	4,293		59,860	187	11
12	21	CLERICAL WAGES	AVAIL. BED DAYS	1,374,590	21	738,904	738,904	59,860	32,177	12
13	21	CLERICAL & GENERAL - OTI	AVAIL. BED DAYS	1,374,590	21	7,880		59,860	343	13
14	24	SEMINARS	AVAIL. BED DAYS	1,374,590	21	19,314		59,860	841	14
15	27	EMP. BEN.-NON-NURSING	AVAIL. BED DAYS	1,374,590	21	819,705		59,860	35,696	15
16	26	INSURANCE	AVAIL. BED DAYS	1,374,590	21	55,168		59,860	2,402	16
17	30	DEPRECIATION	AVAIL. BED DAYS	1,374,590	21	19,384		59,860	844	17
18	34	STORAGE RENTAL	AVAIL. BED DAYS	1,374,590	21	1,500		59,860	65	18
19	35	AUTO RENTAL	AVAIL. BED DAYS	1,374,590	21	29,674		59,860	1,292	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,263,664	$ 7,853,142		$ 403,409	25

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: CF St. Louis LLC
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 676-5300
Fax Number: (847) 676-5348

	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	5	UTILITIES	AVAIL. BED DAYS	1,789,215	30	$ 37,998	$	59,860	$ 1,271	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	1,789,215	30	48,042		59,860	1,607	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,789,215	30	9,551		59,860	320	3
4	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	1,789,215	30	76		59,860	3	4
5	21	OFFICE EXPENSE	AVAIL. BED DAYS	1,789,215	30	32		59,860	1	5
6	26	INSURANCE	AVAIL. BED DAYS	1,789,215	30	9,839		59,860	329	6
7	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,789,215	30	171,679		59,860	5,744	7
8	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,789,215	30	140,710		59,860	4,708	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					$ 417,927	$		$ 13,982	25

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: ReMed Services LLC
Street Address: 3424 Oakton Street, Suite 102
City / State / Zip Code: Skokie, IL
Phone Number: (847) 440-2600
Fax Number: (

	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	10	Medical Supplies	Direct			$	$		$ 7,151	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					$	$		$ 7,151	25

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: ML Group Design and Development
Street Address: 3424 Oakton Street
City / State / Zip Code: Skokie, IL
Phone Number: (847) 676-5300
Fax Number: (

	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	06	Maintenance	Direct			$	$		$ 17,100	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					$	$		$ 17,100	25

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: ProPay HR LLC
Street Address: 2201 W. Main St
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847) 905-3268
Fax Number: ( )

	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	19	Payroll Services	Direct			$	$		$ 20,437	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					$	$		$ 20,437	25

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage			$	$ 24,773,471			$ 1,342,546	1
2	The Private Bank		X	Note Payable				519,962			77,206	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 25,293,433			$ 1,419,751	9
	B. Non-Facility Related*											
10	Interest Income		X								(11,146)	10
11	Allocated from Legacy HC		X								19	11
12	Allocated from CF St. Louis		X								5,744	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,383)	14
15	TOTALS (line 9+line14)						$	$ 25,293,433			$ 1,414,368	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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.)

Facility Name & ID Number Astoria Place # 0053900 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	252,988	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.)	$	259,384	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,396	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	231,316	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.)**	$	234	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.	$	237,946	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	175,726	8
	2013	200,343	9
	2014	204,379	10
	2015	233,006	11
	2016	254,676	12

2017 Accrual - $254,676 x .91 = 231,316 (Rounded)

*Beginning Accrual Adjusted

Allocated from CF St. Louis: $4,708

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Astoria Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053900

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-01-107-030-0000	Long Term Care Property	$ 254,676.45	$ 254,676.45
2.	10-23-406-034-0000	Home Office Allocation	$ 463,439.48	$ 4,707.60
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 718,115.93	$ 259,384.05

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? X YES _____ 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2016 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 real estate tax bill.

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Astoria Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053900

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 _____ 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	Facility			$ 559,576	1
2	Allocated from CF St. Louis, LLC			21,746	2
3	TOTALS			$ 581,322	3

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	164		2012	1973	$ 10,156,976	$	40	$ 253,924	$ 253,924	$ 1,616,918	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2010	1,072,631		20	53,632	53,632	429,052	9
10	Various			2011	110,075		20	5,504	5,504	38,526	10
11	Various			2012	70,976		20	3,549	3,549	21,293	11
12	Various			2013	108,957		20	5,448	5,448	27,239	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		261,409			12,309	12,309	24,361	68
69	Financial Statement Depreciation			83,381			(83,381)		69
70	TOTAL (lines 4 thru 69)		$ 11,781,024	$ 83,381		$ 334,365	$ 250,984	$ 2,157,390	70

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,781,024	$ 83,381		$ 334,365	$ 250,984	$ 2,157,390	1
2	Repave And Strip 2 Parking Lots	2014	13,575		20	679	679	2,715	2
3	Retaining Wall,Sidewalks, West Parking Lot, Stairs To Lower Lvl	2014	22,225		20	1,111	1,111	4,445	3
4	Iron Fence- West Parking Lot Area- Stairs Down To Lower Level	2014	3,000		20	150	150	600	4
5	Wallcovering-2Nd Floor Corridor, California And Dining Rooms	2014	9,014		20	451	451	1,803	5
6	Fire Alarm - Activity Room	2014	7,627		20	381	381	1,525	6
7	Carpentry-Handrails, Fix Walls	2014	19,180		20	959	959	3,836	7
8	2Nd Floor Hallway-Basement-Beauty Shop	2014			20				8
9	2Nd & 3Rd Floor Air Handler	2014	4,266		20	213	213	853	9
10	Replace Outside Condensing Unit - 4Th Floor Sitting Room	2014	3,181		20	159	159	636	10
11	Sprinklers	2014	4,780		20	239	239	956	11
12	Entrance To 1St Floor South Stairwell & 1St Floor Outside Storag	2014			20				12
13	Air Handler Blower - Kitchen	2014	4,886		20	244	244	977	13
14	Replace Kitchen Hood - Kitchen	2014	3,635		20	182	182	727	14
15	Hot Water Heater	2014	9,767		20	488	488	1,953	15
16	Tile - 2Nd Floor Lounge	2014	19,887		20	994	994	3,977	16
17	Wallpaper-2Nd Floor	2014	10,322		20	516	516	2,064	17
18	Furnace - Therapy Room	2014	3,690		20	185	185	738	18
19	Pump - Generator Room And Boiler Room	2014	2,555		20	128	128	511	19
20	4Th Floor Renovation -4Th Floor And 2Nd Floor Dining Room	2014	24,450		20	1,223	1,223	4,890	20
21	Remove Three Layers Of Vct Tiles, Skim Coats	2014			20				21
22	Protect All Working Area, Vct Tiles & Baseboards Installed	2014			20				22
23	Concrete- Parking Lot - Side Walk	2014	11,250		20	563	563	2,250	23
24	Ada Approved P-Traps - All Building	2014	7,250		20	363	363	1,450	24
25	Furnish And Install Patio Containers	2015	6,780		20	339	339	1,017	25
26	Insulated Return Duct In Laundry Ac Unit	2015	3,030		20	152	152	455	26
27	Install Sprinkler Head In 2Nd, 3Rd, 4Th Floors	2015	7,603		20	380	380	1,140	27
28	Furnish And Install Patio Containers	2015	6,780		20	339	339	1,017	28
29	Replace Sump Pump Switches - Rewire To Electrical Rom	2015	3,850		20	193	193	578	29
30	Renovate Activity Room - Walls, Floor, Ceiling, Doors, Bathroom	2015	17,225		20	861	861	2,584	30
31	Electric Work To Tv Outlets And Dishwasher Switch Box Fuse 2N	2015	3,100		20	155	155	465	31
32	Tile Adhesive, Grout, And Rubber Cement - 2Nd Floor	2015	38,268		20	1,913	1,913	5,740	32
33	Demolition And Garbage Disposal, Repair And Prep Concrete Flo	2015	36,225		20	1,811	1,811	5,434	33
34	TOTAL (lines 1 thru 33)		$ 12,088,425	$ 83,381		$ 349,735	$ 266,354	$ 2,212,727	34

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 12,088,425	$ 83,381		$ 349,735	$ 266,354	$ 2,212,727	1
2	Repair Vct Tiles, Painting And Wall Covering, Electric Work	2015			20				2
3	Wiring And New Outlets, Plumbing - 2Nd Floor Nursing Station	2015			20				3
4	3Rd Floor Dining Room A/C Condenser Replacement	2015	3,230		20	162	162	485	4
5	Door Package, Piping, And A/C Service - 2Nd Floor	2015	62,658		20	3,133	3,133	9,399	5
6	Demolition And Garbage Disposal, Ceiling Repair, Painting And	2015	27,850		20	1,393	1,393	4,178	6
7	Wall Covering, Electric Work - Wiring, New Outlets & Switches	2015			20				7
8	Carpentry And Repair Vct Floor - California Room	2015			20				8
9	Replace Mixing Valve On Domestic Hot Water Main Lines	2015	3,430		20	172	172	515	9
10	Changed Sprinkler Heads In 3Rd Floor Patient Rooms	2017	4,605		20	230	230	230	10
11	Repipe Surface Protection Over Range	2017	2,674		20	100	100	100	11
12	Fabricate And Install New Duct , Reinstall Fan	2017	13,315		20	388	388	388	12
13	All Windows Caulked With Exterior Window Sealant	2017	3,500		20	102	102	102	13
14	Installed Amp/Electrical Lighting/Power To Emergency Lights-1S	2017	4,525		20	75	75	75	14
15	Installed New Copper Piping, Ball And Mix Valves	2017	6,495		20	325	325	325	15
16	Replaced Sprinkler Heads	2017	2,834		20	142	142	142	16
17	Modify Cabinets And Countertops	2017	2,950		20	148	148	148	17
18	Installed New Copper And Brass Flanges	2017	4,760		20	238	238	238	18
19	2 Shunt Trip Breakers, New 120V Control Circuit, New Conduit	2017	3,480		20	174	174	174	19
20	Electrical Work - Replace 200A Manual Transfer Switch	2017	8,695		20	435	435	435	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,243,426	$ 83,381		$ 356,950	$ 273,569	$ 2,229,658	34

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 12,243,426	$ 83,381		$ 356,950	$ 273,569	$ 2,229,658	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,243,426	$ 83,381		$ 356,950	$ 273,569	$ 2,229,658	34

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 12,243,426	$ 83,381		$ 356,950	$ 273,569	$ 2,229,658	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
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17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,243,426	$ 83,381		$ 356,950	$ 273,569	$ 2,229,658	34

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from CF St. Louis LLC	2016	35,553		35	1,016	1,016	2,032	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis LLC	2016	220,733		20	11,037	11,037	22,073	9
10	Allocated from CF St. Louis LLC	2017	5,123		20	256	256	256	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	TOTAL (lines 1 thru 33)		$ 261,409	$		$ 12,309	$ 12,309	$ 24,361	34

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 261,409	$		$ 12,309	$ 12,309	$ 24,361	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 261,409	$		$ 12,309	$ 12,309	$ 24,361	34

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 2,540,558	$ 844	$ 254,056	$ 253,212	10	$ 1,126,217	71
72	Current Year Purchases	69,904		7,309	7,309	10	7,309	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,610,462	$ 844	$ 261,365	$ 260,521		$ 1,133,526	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,435,210	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 84,225	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 618,315	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 534,090	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,363,184	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 268,002	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.

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage				9,600			5
6	Allocated from Progressive HC/Legacy HC				160			6
7	TOTAL				$ 9,760 **			7

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 12,840 Description: See Attached Schedule
(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	Facility	Toyota	$ 222	$ 2,231	17
18	Allocated from Legacy HC			3,314	18
19	Allocated from Progressive HC			1,292	19
20					20
21	TOTAL		$ 222	$ 6,837	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 # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

   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.

Facility Name & ID Number Astoria Place STATE OF ILLINOIS # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 409,994	$		$ 409,994	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			111,778			111,778	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			470,401			470,401	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				227,264		227,264	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					37,644	143,933		181,577	13
14	TOTAL			$		$ 1,029,817	$ 371,197		$ 1,401,014	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.

STATE OF ILLINOIS

Facility Name & ID Number Astoria Place **#** 0053900 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 3,374	$ 10,748	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,146,673	2,146,673	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	130,219	130,219	6
7	Other Prepaid Expenses	12,110	68,221	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	339,486	339,486	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,631,862	$ 2,695,347	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		559,576	13
14	Buildings, at Historical Cost	6,495	10,120,501	14
15	Leasehold Improvements, at Historical Cost	620,113	1,936,679	15
16	Equipment, at Historical Cost	170,089	1,420,534	16
17	Accumulated Depreciation (book methods)	(141,420)	(2,083,625)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,014,391	3,078,410	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,669,668	$ 15,032,075	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,301,530	$ 17,727,422	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 872,169	$ 872,169	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	519,962	1,114,046	29
30	Accrued Salaries Payable	309,538	309,538	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,141	8,141	31
32	Accrued Real Estate Taxes(Sch.IX-B)		231,316	32
33	Accrued Interest Payable		122,808	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	58,136	58,136	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,767,946	$ 2,716,154	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		24,179,387	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,737,184		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,737,184	$ 24,179,387	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,505,130	$ 26,895,541	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 796,400	$ (9,168,119)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,301,530	$ 17,727,422	48

***(See instructions.)**

Facility Name & ID Number Astoria Place # 0053900 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 89,138	1
2	Restatements (describe):		2
3	**Rounding**	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 89,141	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	707,259	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)**	$ 707,259	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)**	$ 796,400	24 *

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

Facility Name & ID Number Astoria Place # 0053900 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 17,317,682	1
2	Discounts and Allowances for all Levels	(7,679,047)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,638,635	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,256,960	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,256,960	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	230,567	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,649	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,935	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 271,151	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,146	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,146	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	39,659	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 39,659	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,217,551	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,825,530	31
32	Health Care	4,152,249	32
33	General Administration	1,884,439	33
	B. Capital Expense		
34	Ownership	3,141,782	34
	C. Ancillary Expense		
35	Special Cost Centers	2,109,104	35
36	Provider Participation Fee	397,188	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,510,292	40
41	**Income before Income Taxes (line 30 minus line 40)****	707,259	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 707,259	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,328,290	44
45	Private Pay - Net Inpatient Revenue	598,200	45
46	Medicare - Net Inpatient Revenue	1,378,282	46
47	Other-(specify) Insurance	333,863	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,638,635	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2,024	2,240	$ 145,920	$ 65.14	1
2	Assistant Director of Nursing	1,896	2,143	85,046	39.69	2
3	Registered Nurses	34,399	36,904	1,205,459	32.66	3
4	Licensed Practical Nurses	18,897	19,883	544,673	27.39	4
5	CNAs & Orderlies	86,148	92,635	1,274,400	13.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,872	10,600	230,350	21.73	8
9	Activity Director	1,790	2,086	41,661	19.97	9
10	Activity Assistants	7,682	8,007	90,279	11.28	10
11	Social Service Workers	9,913	10,966	262,518	23.94	11
12	Dietician					12
13	Food Service Supervisor	1,814	2,080	48,793	23.46	13
14	Head Cook	4,018	4,470	75,277	16.84	14
15	Cook Helpers/Assistants	19,350	21,361	297,604	13.93	15
16	Dishwashers					16
17	Maintenance Workers	3,722	4,125	89,315	21.65	17
18	Housekeepers	17,719	19,960	249,125	12.48	18
19	Laundry	2,137	2,323	40,788	17.56	19
20	Administrator	2,056	2,168	103,664	47.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	32	40	1,216	30.40	23
24	Clerical	10,285	10,833	169,759	15.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,638	2,987	73,873	24.73	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	236,392	255,811	$ 5,029,720 *	$ 19.66	34

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

** See instructions.

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	Monthly	$ 8,954	01-03	35
36	Medical Director	Monthly	38,024	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	22,430	10-03	38
39	Pharmacist Consultant	Monthly	12,747	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	596	11-03	44
45	Social Service Consultant	Monthly	5,782	12-03	45
46	Other(specify) Clergy	Monthly	5,500	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 94,033		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				51
52	Certified Nurse Assistants/Aides	25	500	10-03	52
53	TOTAL (lines 50 - 52)	25	$ 500		53

Facility Name & ID Number Astoria Place # 0053900 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jonathan Dauber	Administrator	0	$ 61,112
William Pfeiffer	Administrator	0	42,552
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,664

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum	Accounting	$ 21,558
RSM McGladrey	Accounting	9,785
Paycor	Payroll Services	26,891
Achieve Accreditation	Accreditation Maintenance	4,290
PSD Solutions	Technology Consultant	894
Prospect Resources	Energy Procurement	1,000
McCabe Kirshner	Insurance Solutions Consulting	896
BlueOrange Compliance	Cyber Security Solutions	1,352
IIT/Sourcetech	Operator Support	1,790
Lexis Nexis Risk Solutions	Data Management	51
Personnel Planners	Unemployment Consulting	915
See Supplemental Schedule		46,646
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 116,068

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,768
Unemployment Compensation Insurance	42,276
FICA Taxes	377,754
Employee Health Insurance	215,342
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	29,307
401K Expense	5,267
Employee Physical Exams	10,878
Voluntary Benefit Contributions	8,072
Other Employee Benefits	32,921
TOTAL (agree to Schedule V, line 22, col.8)	$ 795,585

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	142
Health Care Worker Background Check	
(Indicate # of checks performed 580)	5,800
Patient Background Checks 161	1,605
Dues & Subscriptions	24,358
Licenses & Permits	13,706
Allocated from Legacy HC	890
Allocated from Progressive HC	187
Allocated from CF St. Louis	3
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,690

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,752
Allocated from Legacy HC	1,176
Allocated from Progressive HC	841
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,769

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Astoria Place # 0053900 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $14,768; IHCA - $11,072**

(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. $ **44,206** Line **10**

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **397,188**
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. $ 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? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees