

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0045823</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>ASTA CARE CENTER OF FORD COUNTY, LLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1240 N. MARKET STREET</u> <u>PAXTON</u> <u>60957</u>																									
Number City Zip Code																									
County: <u>FORD</u>																									
Telephone Number: <u>(847) 742-8822</u> Fax # <u>(847) 742-9013</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>MICHAEL GILLMAN</u></td></tr><tr><td>(Title) <u>MEMBER</u></td></tr><tr><td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name <u>BOB KAGDA</u> and Title) <u>VICE PRESIDENT</u></td></tr><tr><td>(Firm Name <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> & Address) <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MICHAEL GILLMAN</u>	(Title) <u>MEMBER</u>	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)	Paid Preparer	(Date) _____	(Print Name <u>BOB KAGDA</u> and Title) <u>VICE PRESIDENT</u>	(Firm Name <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> & Address) <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>												
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	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																								
Date of Initial License for Current Owners: <u>07/01/02</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u>																									
Email Address: _____																									

Facility Name & ID Number ASTA CARE CENTER OF FORD COUNTY, LLC

0045823 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>69</u>	Skilled (SNF)	<u>69</u>	<u>25,185</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>69</u>	TOTALS	<u>69</u>	<u>25,185</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,531</u>		<u>2,110</u>	<u>3,641</u>	8
9	SNF/PED					9
10	ICF	<u>16,882</u>	<u>2,026</u>	<u>282</u>	<u>19,190</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,413</u>	<u>2,026</u>	<u>2,392</u>	<u>22,831</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.65%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☐

NO

X

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

07/01/02

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

YES

X

Date 07/02/02

NO

☐

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

YES

X

NO

☐

If YES, enter number

of beds certified

69

and days of care provided

2,069

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: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number ASTA CARE CENTER OF FORD COUNTY # 0045823 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	200,615	14,697	12,289	227,601		227,601		227,601			1
2	Food Purchase		127,768		127,768		127,768	(772)	126,996			2
3	Housekeeping	169,611	18,316		187,927		187,927		187,927			3
4	Laundry		11,240		11,240		11,240		11,240			4
5	Heat and Other Utilities			85,363	85,363		85,363		85,363			5
6	Maintenance	43,247	11,207	18,732	73,186		73,186		73,186			6
7	Other (specify):*			7,301	7,301		7,301		7,301			7
8	TOTAL General Services	413,473	183,228	123,685	720,386		720,386	(772)	719,614			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,074,965	95,359	7,080	1,177,404		1,177,404	7,250	1,184,654			10
10a	Therapy		6,682		6,682		6,682		6,682			10a
11	Activities	69,287	7,129		76,416		76,416		76,416			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,144,252	109,170	16,080	1,269,502		1,269,502	7,250	1,276,752			16
	C. General Administration											
17	Administrative	82,042		202,500	284,542		284,542	(79,193)	205,349			17
18	Directors Fees											18
19	Professional Services			72,317	72,317		72,317	4,008	76,325			19
20	Dues, Fees, Subscriptions & Promotions			15,646	15,646		15,646	(5,461)	10,185			20
21	Clerical & General Office Expenses	70,835	14,377	35,480	120,692		120,692	8,283	128,975			21
22	Employee Benefits & Payroll Taxes			276,669	276,669		276,669		276,669			22
23	Inservice Training & Education			885	885		885		885			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			13,297	13,297		13,297	(4,872)	8,425			25
26	Insurance-Prop.Liab.Malpractice			53,499	53,499		53,499	1,250	54,749			26
27	Other (specify):*			40,583	40,583		40,583	(35,110)	5,473			27
28	TOTAL General Administration	152,877	14,377	710,876	878,130		878,130	(111,095)	767,035			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,710,602	306,775	850,641	2,868,018		2,868,018	(104,617)	2,763,401			29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,590
	REPAIRS & MAINTENANCE	6,699
		0
		12,289
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	22,195
	ELECTRICITY	34,827
	WATER	28,341
	CABLE TV - LOBBY	0
		0
		85,363
6	MAINTENANCE	
	GROUPS MAINTENANCE	4,648
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,649
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,700
	FIRE SERVICE	2,735
		0
		0
		0
		0
		18,732
7	OTHER	
	SCAVENGER	7,301
	SECURITY SERVICE	0
		0
		0
		7,301
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,000
		9,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	1,370
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	780
	PHARMACY CONSULTANT XVIII B 39-2	4,103
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	827
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		7,080
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	202,500
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	18,063
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	54,254
		0
		72,317
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,361
	EMPLOYEE WANT ADS XIX F	2,528
	CONTRIBUTIONS VI 20 XIX F	1,250
	DUES & SUBSCRIPTIONS XIX F	3,089
	LICENSES & PERMITS XIX F	2,765
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,143
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	580
	PATIENT BACKGROUND CHECKS XIX F	930
		15,646
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	8,355
	EQUIPMENT REPAIR & MAINTENANCE	3,249
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	8,122
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	15,754
	MESSENGER SERVICE	0
		0
		35,480

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	129,546
	UNEMPLOYMENT COMPENSATION XIX D	46,678
	WORKERS COMPENSATION INSURANC XIX D	85,826
	HOSPITALIZATION INSURANCE XIX D	12,851
	EMPLOYEE BENEFITS - OTHER XIX D	1,768
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		276,669
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	885
		885
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	13,297
		13,297
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	53,499
		53,499
27	OTHER	
	BAD DEBTS VI 24	40,583
		40,583

GRAND TOTAL COLUMN 3 OTHER

850,641

ASTA CARE CENTER OF FORD COUNTY, LLC
SCHEDULES
12/31/2011

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	127,768
LESS SALES TAX	<u>(772)</u>
NET FOOD	126,996

TOTAL PATIENT CENSUS	22,831
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	68,493

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	68,493
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	68,493

NET FOOD	126,996
DIVIDE TOTAL MEALS/YEAR	<u>68,493</u>

COST PER MEAL	1.85
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			9,485	9,485		9,485	59,252	68,737			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,046	35,046		35,046	68,204	103,250			32
33	Real Estate Taxes			23,477	23,477		23,477		23,477			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles			12,570	12,570		12,570		12,570			35
36	Other (specify):*											36
37	TOTAL Ownership			260,578	260,578		260,578	(52,544)	208,034			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,388	399,533	482,921		482,921	(65,640)	417,281			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			101,131	101,131		101,131		101,131			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		83,388	500,664	584,052		584,052	(65,640)	518,412			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,710,602	390,163	1,611,883	3,712,648		3,712,648	(222,801)	3,489,847			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,545	30		9
10	Interest and Other Investment Income	(5,687)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(772)	2		13
14	Non-Care Related Interest	(2,147)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(8,122)	21		18
19	Entertainment		20		19
20	Contributions	(2,393)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,583)	27		24
25	Fund Raising, Advertising and Promotional	(3,361)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(84,546)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (143,066)		\$	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)	(79,735)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (79,735)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (222,801)		37

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

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

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

STATE OF ILLINOIS

ASTA CARE CENTER OF FORD COUNTY, LLC

Report Period Beginning:

Ending:

ID#

0045823

01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	NON-ALLOWABLE TRAVEL-MARKETING	(8,528)	25	2
3	RELATED PARTY THERAPY ADJUSTMENT	(65,640)	39	3
4	MARKETING SALARY	(10,378)	21	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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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	(84,546)		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

[illegible]

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
				ASTA		
				HEALTHCARE CO.	ELGIN	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				ASTA PAXTON	ELGIN	LANDLORD
				PROPERTIES		
				ASTA THERAPY	ELGIN	THERAPY

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 127,500	ASTA HEALTHCARE COMPANY		\$	(127,500)	1
2	V	10	NURSING				7,250	7,250	2
3	V	17	ADMINISTRATIVE				48,307	48,307	3
4	V	19	PROFESSIONAL FEES				4,008	4,008	4
5	V	20	LICENSES & PERMITS				293	293	5
6	V	21	OFFICE EXPENSE				26,783	26,783	6
7	V	25	STAFF TRANS/ TRAVEL				3,656	3,656	7
8	V	27	PAYR TAXES & W/C INS				5,473	5,473	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 127,500			\$ 95,770	\$ * (31,730)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 180,000	ASTA PAXTON PROPERTIES, LLC		\$	(180,000)	15
16	V	26	INSURANCE- BUILDERS RISK		ASTA PAXTON PROPERTIES, LLC		1,250	1,250	16
17	V	30	DEPRECIATION		ASTA PAXTON PROPERTIES, LLC		54,707	54,707	17
18	V	32	INTEREST		ASTA PAXTON PROPERTIES, LLC		76,038	76,038	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			\$ 180,000			\$ 131,995	\$ * (48,005)	39

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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 ASTA CARE CENTER OF FORD COUNTY # 0045823 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN	PRESIDENT	administrative/	60.00				SALARY	\$ 24,063	17-7	1
2			management								2
3											3
4					SEE	SEE					4
5	CRAIG FRANK	CFO	finance manage.	10.00	ATTACHED	ATTACHED		SALARY	20,153	17-7	5
6	SALARY FROM ASTA CARE OF FORD COUNTY \$4,969				SCHEDULE	SCHEDULE		SALARY	4,969	17-1	6
7	MANAGEMENT FEE FROM ASTA CARE OF FORD COUNTY \$75,000							MNGT FEE	75,000	17-3	7
8											8
9	DAVID MEISELMAN	THERAPY MGMNT	management	10.00				SALARY	39,286	17-7	9
10											10
11											11
12	ALIZA FRANK	PAYROLL CLERK	PAYROLL					SALARY	4,091	17-7	12
13								TOTAL	\$ 167,562		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 ASTA CARE CENTER OF FORD COUNTY, LLC # 0045823 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 ASTA HEALTHCARE
Street Address 134 N. MCLEAN
City / State / Zip Code ELGIN,IL 60123
Phone Number (847)742-8822
Fax Number (847)742-9013

	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	NURSING	PATIENT DAYS	189,761	7	\$ 60,259	\$ 57,558	22,831	\$ 7,250	1
2	17	OFFICER'S SALARY -MG	PATIENT DAYS	189,761	7	200,000	200,000	22,831	24,063	2
3	17	ADMIN. SALARY -CF	PATIENT DAYS	189,761	7	167,500	167,500	22,831	20,153	3
4	17	ADMIN. SALARY -AF	PATIENT DAYS	189,761	7	34,000	34,000	22,831	4,091	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	189,761	7	33,313		22,831	4,008	5
6	20	LICENSES & PERMITS	PATIENT DAYS	189,761	7	2,436		22,831	293	6
7	21	OFFICE EXPENSE	PATIENT DAYS	189,761	7	222,607	160,308	22,831	26,783	7
8	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	189,761	7	30,383		22,831	3,656	8
9	27	PAYR. TAXES & W/C	PATIENT DAYS	189,761	7	45,486		22,831	5,473	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					\$ 795,984	\$ 619,366		\$ 95,770	25

Facility Name & ID Number ASTA CARE CENTER OF FORD COUNTY, LLC # 0045823 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 ASTA PAXTON PROPERTIES
Street Address 134 N. MCLEAN
City / State / Zip Code ELGIN,IL 60123
Phone Number (847)742-8822
Fax Number (847)742-9013

	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	26	INSUR- BUILDERS RISK	DIRECT	1	\$ 1,250	\$	1	\$ 1,250	1
	2	30	DEPRECIATION	DIRECT	1	54,707		1	54,707	2
	3	32	INTEREST		1	76,038		1	76,038	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				\$ 131,995	\$		\$ 131,995	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	RELATED PARTY						\$		\$			\$							1
2	COLE TAYLOR BANK		X	MORTGAGE					926,667								70,020		2
3	LOAN COSTS		X	LOAN COSTS				30,092	9,530								6,018		3
4																			4
5	CATERPILLAR		X	GENERATOR PURCH	\$438.00			22,858	4,410	7/14/15		0.0560					1,157		5
	Working Capital																		
6	COLE TAYLOR BANK		X	WORKING CAPITAL		REVOLV			896,608	REVOLV							27,047		6
7	INSURANCE POLICIES		X	INTEREST ON INSURANCE													1,526		7
8	MEMBER LOAN	X		WORKING CAPITAL													3,169		8
9	TOTAL Facility Related				\$438.00		\$	52,950	\$	1,837,215				\$	108,937				9
	B. Non-Facility Related*																		
10																			10
11	IDPA		X	BED TAX													2,147		11
12				MIS															12
13																			13
14	TOTAL Non-Facility Related						\$		\$				\$	2,147					14
15	TOTALS (line 9+line14)						\$	52,950	\$	1,837,215				\$	111,084				15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ N/A

Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.			\$	32,296	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.)			\$	27,886	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(4,409)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	27,886	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.			\$		5
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.			\$	23,477	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	29,792	8	
		2007	30,473	9	
		2008	32,210	10	
		2009	32,296	11	
		2010	27,886	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.				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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF FORD COUNTY, LLC COUNTY FORD

FACILITY IDPH LICENSE NUMBER 0045823

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>11-14-05-300-001</u>	<u>NURSING HOME</u>	\$ <u>27,886.14</u>	\$ <u>27,886.14</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>27,886.14</u></u>	\$ <u><u>27,886.14</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800

B. General Construction Type: Exterior BRICK/WOOD Frame _____ Number of Stories _____

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

If so, please complete the following:

1. Total Amount Incurred: _____

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

3. Current Period Amortization: _____

4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>		<u>2008</u>	<u>\$ 125,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			<u>\$ 125,000</u>	<u>3</u>

Facility Name & ID Number ASTA CARE CENTER OF FORD COUNTY, LLC

0045823

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	69		2008		\$ 992,215	\$ 36,081	27.5	\$ 36,081	\$	\$ 124,780
5										
6										
7										
8										
	Improvement Type**									
9	NURSE STATION			2002	10,000	364	27.5	364		3,412
10	ROOF			2002	28,434	1,034	27.5	1,034		9,694
11	NURSE STATION			2002	10,000	363	27.5	363		3,403
12	ROOF			2004	31,800	1,156	27.5	1,156		9,200
13	ELECTRICAL WORK			2005	3,959	144	27.5	144		942
14	SECURITY SYSTEM			2005	35,650	1,296	27.5	1,296		10,385
15	ASPHALT SIDEWALK			2005	2,200	147	15	147		937
16	10 TON PKG UNIT			2006	8,500	309	27.5	309		1,635
17	EMERGENCY SWITCH PANEL			2006	1,828	66	27.5	66		349
18	TILING			2006	1,091	40	27.5	40		212
19	WATER HEATER			2007	8,943	325	27.5	325		1,530
20	WATER MAIN WORK			2007	6,857	457	15	457		1,885
21	FLOORING			2007	11,440	1,318	5	2,288	970	10,296
22	DRAIN REPAIR (REL PARTY)			2008	8,612	313	27.5	313		1,109
23	FLOORING (REL PARTY)			2008	2,539	92	27.5	92		303
24	GENERATOR (REL PARTY)			2008	6,569	239	27.5	239		747
25	ELECTRICAL WORK (REL PARTY)			2009	4,395	160	27.5	160		420
26	WATER HEATER (REL PARTY)			2009	10,765	391	27.5	391		1,026
27	GENERATOR (REL PARTY)			2010	29,504	1,073	27.5	1,073		2,101
28	TILING (REL PARTY)			2010	3,426	124	27.5	124		243
29	CONCRETE RAMP(REL PARTY)			2010	3,000	200	15	200		300
30	ROOFTOP PACKAGE AIR CONDITIONER WITH GAS HEAT			2011	8,135	136	27.5	136		136
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,229,862	\$ 45,828		\$ 46,798	\$ 970	\$ 185,045	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 48,804	\$ 2,466	\$ 4,881	\$ 2,415	10 YRS	\$ 27,141	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY	138,000	15,898	13,800	(2,098)		48,300	74
75	TOTALS	\$ 186,804	\$ 18,364	\$ 18,681	\$ 317		\$ 75,441	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	FACILITY	2001 FORD VAN	2005	\$ 16,288	\$	\$ 3,258	\$ 3,258	5 YRS	\$ 16,290	76
77										77
78										78
79										79
80	TOTALS			\$ 16,288	\$	\$ 3,258	\$ 3,258		\$ 16,290	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,557,954	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,192	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,737	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,545	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 276,776	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		\$	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
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:				\$0			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$12,570
- Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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)	\$			

- (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.

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	

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

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 114,187	\$		\$ 114,187	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			21,600			21,600	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			254,432			254,432	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				83,308		83,308	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
	Radiology,Lab,IV.Therapy,Other services	39-8				9,314			9,314	
13	Other (specify): Med.Supplies	39-8					80		80	13
14	TOTAL			\$		\$ 399,533	\$ 83,388		\$ 482,921	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,530	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (35,000))	1,471,846		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,535		6
7	Other Prepaid Expenses	1,072		7
8	Accounts Receivable (owners or related parties)	104,109		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,599,092	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	149,262		15
16	Equipment, at Historical Cost	76,532		16
17	Accumulated Depreciation (book methods)	(117,410)		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): SECURITY DEPOSIT	431		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 108,815	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,707,907	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 814,674	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	901,018		29
30	Accrued Salaries Payable	36,316		30
31	Accrued Taxes Payable (excluding real estate taxes)	159,807		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,886		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,939,701	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	123,469		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 123,469	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,063,170	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (355,263)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,707,907	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (756,412)	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)	\$ (756,409)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	401,146	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)	\$ 401,146	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)	\$ (355,263)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number ASTA CARE CENTER OF FORD COUNTY, LLC # 0045823Report Period Beginning: 01/01/2011Ending: 12/31/2011

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,897,790	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,897,790	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	201,785	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 201,785	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,687	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,687	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,105,262	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	720,386	31
32	Health Care	1,269,502	32
33	General Administration	878,130	33
	B. Capital Expense		
34	Ownership	260,578	34
	C. Ancillary Expense		
35	Special Cost Centers	482,921	35
36	Provider Participation Fee	101,131	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(8,532)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,704,116	40
41	Income before Income Taxes (line 30 minus line 40)**	401,146	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 401,146	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,766	1,925	\$ 53,350	\$ 27.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,253	2,609	62,269	23.87	3
4	Licensed Practical Nurses	16,177	17,635	379,186	21.50	4
5	CNAs & Orderlies	47,638	51,759	551,849	10.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,988	2,276	35,313	15.52	9
10	Activity Assistants	2,977	3,346	33,974	10.15	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,032	2,281	45,962	20.15	13
14	Head Cook	4,642	5,160	54,535	10.57	14
15	Cook Helpers/Assistants	10,418	11,555	100,118	8.66	15
16	Dishwashers					16
17	Maintenance Workers	2,119	2,390	43,247	18.09	17
18	Housekeepers	15,450	17,224	169,611	9.85	18
19	Laundry					19
20	Administrator	2,207	2,379	82,042	34.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,028	4,244	70,835	16.69	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	1,978	2,150	28,311	13.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,673	126,933	\$ 1,710,602 *	\$ 13.48	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 5,590	1-3	35
36	Medical Director	O	9,000	9-3	36
37	Medical Records Consultant	N	780	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,103	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) <u>PSYCHIATRIC</u>	S	827	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 20,300		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
KIM HAAS	ADMINISTRATOR		\$ 77,073	Workers' Compensation Insurance		\$ 85,826	IDPH License Fee	\$ 1,990
CRAIG FRANK	OTHER ADMINISTRATOR	10	4,969	Unemployment Compensation Insurance		46,678	Advertising: Employee Recruitment	2,528
			0	FICA Taxes		129,546	Health Care Worker Background Check	580
				Employee Health Insurance		12,851	(Indicate # of checks performed 16)	
				Employee Meals		0	Patient Background Checks	10 930
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	2,393
				EMPLOYEE BENEFITS - OTHER		1,768	MARKETING/ADV/PROMO	3,361
				EMPLOYEE PHYSICAL EXAMS		0	LICENSES/DUES/SUBSCRIPTIONS	3,864
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOC	293
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(2,393)
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(3,361)
Description			Amount				Yellow page advertising	(0)
ASTA HEALTHCARE MANAGEMENT			\$ 127,500					
CRAIG FRANK			75,000					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V, line 22, col.8)		\$ 276,669	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,185
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							Seminar Expense	
								0
							Entertainment Expense	()
SEE SCHEDULE ATTACHED			72,317				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$
(If total legal fees exceed \$5,000, attach copy of invoices.)								
			\$ 72,317					

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

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

NO
- (2)

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

YES

If YES, give association name and amount.

IL Healthcare Assoc. \$2,666
- (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?
- (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 YR
- (6)

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

\$ 28,488

Line 10-2
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.
- (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.

\$ 101,131

This amount is to be recorded on line 42 of Schedule V.
- (12)

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

NO

If YES, attach an explanation of the allocation.

- (13)

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

YES
- (14)

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

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

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

\$ 0

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$
- (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.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

5%

d. Have vehicle usage logs been maintained?

NO

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

NO

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

YES

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:
- (18)

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

YES
- (19)

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

YES

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