

		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>0041608</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>ASTA CARE CENTER OF ELGIN, 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>134 N. MCCLEAN BOULEVARD</u> <u>ELGIN</u> <u>60123</u>			
NumberCityZip Code			
County: <u>KANE</u>			
Telephone Number: <u>(847) 742-8822</u> Fax # <u>(847) 742-9013</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>03/29/96</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other _____			

☐ GOVERNMENTAL☐ State☐ County☐ Other _____

Facility Name & ID Number ASTA CARE CENTER OF ELGIN, LLC

0041608 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>52</u>	Skilled (SNF)	<u>52</u>	<u>18,980</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>50</u>	Intermediate (ICF)	<u>50</u>	<u>18,250</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>102</u>	TOTALS	<u>102</u>	<u>37,230</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>241</u>	<u>10</u>	<u>5,151</u>	<u>5,402</u>	8
9	SNF/PED					9
10	ICF	<u>23,380</u>	<u>1,694</u>	<u>408</u>	<u>25,482</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,621</u>	<u>1,704</u>	<u>5,559</u>	<u>30,884</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.95%

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 ☒

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

I. On what date did you start providing long term care at this location?
Date started 03/29/96

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 03/29/96 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 52 and days of care provided 4,797

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN, LLC # 0041608 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	300,058	25,100	13,107	338,265		338,265		338,265			1
2	Food Purchase		184,446		184,446		184,446	(1,139)	183,307			2
3	Housekeeping	279,284	27,208		306,492		306,492		306,492			3
4	Laundry	80,202	18,619		98,821		98,821		98,821			4
5	Heat and Other Utilities			116,442	116,442		116,442		116,442			5
6	Maintenance	61,652	35,045	41,995	138,692		138,692		138,692			6
7	Other (specify):*			47,097	47,097		47,097		47,097			7
8	TOTAL General Services	721,196	290,418	218,641	1,230,255		1,230,255	(1,139)	1,229,116			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,557,074	177,465	31,514	1,766,053		1,766,053	9,807	1,775,860			10
10a	Therapy	140,121	1,385	649	142,155		142,155		142,155			10a
11	Activities	128,582	15,719		144,301		144,301		144,301			11
12	Social Services	112,595		7,060	119,655		119,655		119,655			12
13	CNA Training											13
14	Program Transportation			1,691	1,691		1,691		1,691			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,938,372	194,569	49,914	2,182,855		2,182,855	9,807	2,192,662			16
	C. General Administration											
17	Administrative	129,670		290,000	419,670		419,670	(224,655)	195,015			17
18	Directors Fees											18
19	Professional Services			91,926	91,926		91,926	5,422	97,348			19
20	Dues, Fees, Subscriptions & Promotions			22,459	22,459		22,459	(9,604)	12,855			20
21	Clerical & General Office Expenses	163,533	25,519	56,472	245,524		245,524	5,870	251,394			21
22	Employee Benefits & Payroll Taxes			381,333	381,333		381,333		381,333			22
23	Inservice Training & Education			1,262	1,262		1,262		1,262			23
24	Travel and Seminar			3,668	3,668		3,668	(1,637)	2,031			24
25	Other Admin. Staff Transportation			1,667	1,667		1,667	4,945	6,612			25
26	Insurance-Prop.Liab.Malpractice			88,263	88,263		88,263		88,263			26
27	Other (specify):*			155,947	155,947		155,947	(148,544)	7,403			27
28	TOTAL General Administration	293,203	25,519	1,092,997	1,411,719		1,411,719	(368,203)	1,043,516			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,952,771	510,506	1,361,552	4,824,829		4,824,829	(359,535)	4,465,294			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	8,777
	REPAIRS & MAINTENANCE	4,330
		0
		13,107
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	31,854
	ELECTRICITY	36,827
	WATER	37,376
	CABLE TV - LOBBY	10,385
		0
		116,442
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,332
	PAINTING & DECORATING	2,283
	BUILDING REPAIRS	2,246
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	22,796
	ELEVATOR MAINTENANCE & REPAIR	1,765
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,375
	FIRE SERVICE	8,198
		0
		0
		0
		0
		41,995
7	OTHER	
	SCAVENGER	47,097
	SECURITY SERVICE	0
		0
		0
		47,097
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	0
	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	784
	PHARMACY CONSULTANT XVIII B 39-2	5,280
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	NURSING PROGRAM CONSULTANT	450
	LAWSUIT SETTLEMENT	25,000
		31,514
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	649
	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
		649
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	4,324
	SOCIAL WORKER XVIII B 45-2	2,736
		7,060
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	1,691
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	290,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	24,925
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	67,001
		0
		91,926
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,851
	EMPLOYEE WANT ADS XIX F	313
	CONTRIBUTIONS VI 20 XIX F	1,460
	DUES & SUBSCRIPTIONS XIX F	6,335
	LICENSES & PERMITS XIX F	4,253
	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	1,689
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	330
	PATIENT BACKGROUND CHECKS XIX F	1,228
		22,459
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	9,370
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	11,822
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	33,565
	MESSENGER SERVICE	1,715
		0
		56,472

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	224,163
	UNEMPLOYMENT COMPENSATION XIX D	63,707
	WORKERS COMPENSATION INSURANC XIX D	64,358
	HOSPITALIZATION INSURANCE XIX D	26,755
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	2,350
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		381,333
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,262
		1,262
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	3,668
		3,668
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,667
		1,667
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	88,263
		88,263
27	OTHER	
	BAD DEBTS VI 24	155,947
		155,947

GRAND TOTAL COLUMN 3 OTHER

1,361,552

ASTA CARE CENTER OF ELGIN, LLC
SCHEDULES
12/31/2011

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

TOTAL FOOD PURCHASE	184,446
LESS SALES TAX	<u>(1,139)</u>
NET FOOD	183,307
TOTAL PATIENT CENSUS	30,884
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	92,652
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	92,652
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	92,652
NET FOOD	183,307
DIVIDE TOTAL MEALS/YEAR	<u>92,652</u>
COST PER MEAL	1.98
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			39,113	39,113		39,113	(5,105)	34,008			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,137	46,137		46,137	(7,326)	38,811			32
33	Real Estate Taxes			23,133	23,133		23,133		23,133			33
34	Rent-Facility & Grounds			464,280	464,280		464,280		464,280			34
35	Rent-Equipment & Vehicles			32,576	32,576		32,576		32,576			35
36	Other (specify):*											36
37	TOTAL Ownership			605,239	605,239		605,239	(12,431)	592,808			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		251,730	666,545	918,275		918,275	(120,160)	798,115			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,178	134,178		134,178		134,178			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		251,730	800,723	1,052,453		1,052,453	(120,160)	932,293			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,952,771	762,236	2,767,514	6,482,521		6,482,521	(492,126)	5,990,395			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	(5,105)	30		9
10	Interest and Other Investment Income	(1,740)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,139)	2		13
14	Non-Care Related Interest	(5,586)	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	(11,822)	21		18
19	Entertainment		20		19
20	Contributions	(3,149)	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	(155,947)	27		24
25	Fund Raising, Advertising and Promotional	(6,851)	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	(140,335)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (331,674)		\$	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)	(160,452)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (160,452)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (492,126)		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

	ID#	0041608
Report Period Beginning:		01/01/2011
Ending:		12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	NON-ALLOWABLE MARKETING TRAVEL	(1,637)	24	2
3	RELATED PARTY THERAPY ADJUSMENT	(120,160)	39	3
4	MARKETING SALARY	(18,538)	21	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
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	(140,335)		49

Summary B

12/31/2011

[illegible]

Facility Name & ID Number	ASTA CARE CENTER OF ELGIN, LLC	#	0041608	Report Period Beginning:	01/01/2011	Ending:	12/31/2011
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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 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	\$ 290,000	ASTA HEALTHCARE COMPANY, INC.		\$	(290,000)	1
2	V	10	NURSING				9,807	9,807	2
3	V	17	ADMINISTRATIVE				65,345	65,345	3
4	V	19	PROFESSIONAL FEES				5,422	5,422	4
5	V	20	LICENSES & PERMITS				396	396	5
6	V	21	OFFICE EXPENSE				36,230	36,230	6
7	V	25	STAFF TRANS/ TRAVEL				4,945	4,945	7
8	V	27	PAYR TAXES & W/C INS				7,403	7,403	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 290,000			\$ 129,548	\$ * (160,452)	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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 ELGIN, LLC # 0041608 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/management	40.00				SALARY	\$ 32,550	17-7	1
2											2
3											3
4	CRAIG FRANK	CFO	finance manage.		SEE	SEE		SALARY	27,261	17-7	4
5					ATTACHED	ATTACHED					5
6					SCHEDULE	SCHEDULE					6
7											7
8	DAVID MEISELMAN	THERAPY MGMNT	management					SALARY	39,286	39-7	8
9											9
10											10
11	ALIZA FRANK	PAYROLL CLERK	PAYROLL	7.50				SALARY	5,534	17-7	11
12											12
13								TOTAL	\$ 104,631		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 ELGIN, LLC # 0041608 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 COMPANY
Street Address 134 NORTH MCLEAN BLVD
City / State / Zip Code ELGIN, IL 60123
Phone Number (847) 742 - 8822
Fax Number (847) 742 - 9013

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	10	NURSING	PATIENT DAYS	189,761	7	\$ 60,259	\$ 57,558	30,884	\$ 9,807	1
2	17	OFFICER'S SALARY -MG	PATIENT DAYS	189,761	7	200,000	200,000	30,884	32,550	2
3	17	ADMIN. SALARY -CF	PATIENT DAYS	189,761	7	167,500	167,500	30,884	27,261	3
4	17	ADMIN. SALARY -AF	PATIENT DAYS	189,761	7	34,000	34,000	30,884	5,534	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	189,761	7	33,313		30,884	5,422	5
6	20	LICENSES & PERMITS	PATIENT DAYS	189,761	7	2,436		30,884	396	6
7	21	OFFICE EXPENSE	PATIENT DAYS	189,761	7	222,607	160,308	30,884	36,230	7
8	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	189,761	7	30,383		30,884	4,945	8
9	27	PAYR. TAXES & W/C	PATIENT DAYS	189,761	7	45,486		30,884	7,403	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		\$ 129,548	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							\$					\$	1	
2	MEMBER LOANS	X										2,322	2	
3	N/P - SCHLUSSEL			WORKING CAPITAL	\$1,594.00	9/1/10	75,000	62,728	9/1/15	10.0000		6,541	3	
4	N/P - MEISELMAN			WORKING CAPITAL	\$1,594.00	9/1/10	75,000	62,728	9/1/15	10.0000		6,437	4	
5	N/P PRNCE			WORKING CAPITAL	\$1,062.00	11/1/10	50,000	43,365	11/1/15	10.0000		4,430	5	
	Working Capital													
6	FIRST CHICAGO BANK		X	WORKING CAPITAL	INT	REVOLV			193480	REVOLV		17,788	6	
7	MARLIN LEASING		X	GENERAROR PURCHASE	\$1,248.00	8/23/11	46,275	44,715	11/23/15	10.0000		1,274	7	
8	INSURANCE POLICIES		X									1,759	8	
9	TOTAL Facility Related				\$5,498.00		\$ 246,275	\$ 213,536			\$ 40,551	9		
	B. Non-Facility Related*													
10	BED TAX											5,586	10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	\$			\$ 5,586	14		
15	TOTALS (line 9+line14)						\$ 246,275	\$ 213,536			\$ 46,137	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

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	89,907	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.)				\$	56,520	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	(33,387)	3																				
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	56,520	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.				\$	23,133	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:	2006	84,432	8	<table border="1"> <tr> <td></td> <td colspan="2">FOR BHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2010</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>				FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2010	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13																							
14	PLUS APPEAL COST FROM LINE 5	\$	14																							
15	LESS REFUND FROM LINE 6	\$	15																							
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																							
	2007	83,945	9																							
	2008	84,942	10																							
	2009	89,907	11																							
	2010	56,520	12																							
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL																										
THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.																										

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ **B. General Construction Type:** _____ **Exterior** _____ **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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number ASTA CARE CENTER OF ELGIN, LLC

0041608

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOOR DRAIN			1997	1,297	33	39	33		480	9
10	INSTALL SHOWER VALVE AND DRAIN			1997	4,142	105	39	105		1,528	10
11	RE KEY DOOR LOCKS			1997	4,085	104	39	104		1,513	11
12	NEW AIR VENTS			1997	616	18	39	18		261	12
13	FIRE ALARM SYSTEM			1997	2,192	56	39	56		814	13
14	AWNINGS			1997	1,020	26	39	26		378	14
15	SEWAGE EJECTOR PUMP			1998	3,961	102	39	102		1,389	15
16	HOT WATER PUMP			1998	5,439	139	39	139		1,836	16
17	AWNINGS			1999	685	25	27.5	25		314	17
18	FLOORING			1999	2,474	90	27.5	90		1,129	18
19	ELECTRICAL WORK			1999	9,378	341	27.5	341		4,277	19
20	MAGNETIC DOOR LOCKS			1999	2,054	74	27.5	74		928	20
21	FIRE SPRINKLER SYSTEM			1999	3,868	141	27.5	141		1,768	21
22	BOILER			1999	4,890	178	27.5	178		2,232	22
23	NURSE STATION			2000	16,280	592	27.5	592		6,833	23
24	CONDENSING UNIT			2000	4,683	170	27.5	170		1,962	24
25	WATER HEATER			2000	8,731	317	27.5	317		3,659	25
26	POWER VENT FOR WATER HEATER			2000	2,682	98	27.5	98		1,131	26
27	NEW WALLS			2000	2,000	73	27.5	73		842	27
28	HOT WATER PIPING			2000	4,708	171	27.5	171		1,974	28
29	DRAPERIES			2000	2,303		7			2,303	29
30	EJECTOR PUMP			2001	14,041	511	27.5	511		5,387	30
31	ROOF			2001	6,218	226	27.5	226		2,382	31
32	COMPRESSOR			2001	3,501	127	27.5	127		1,339	32
33	PRESSURE BACK FLOW PREVENTER			2002	3,870	141	27.5	141		1,345	33
34	FIRE ALARM SYSTEM			2002	37,625	1,368	27.5	1,368		13,053	34
35	RE KEY LOCKS			2002	1,346	49	27.5	49		468	35
36	PATIENT SECURITY SYSTEM			2002	2,719	99	27.5	99		944	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 ASTA CARE CENTER OF ELGIN, LLC

0041608

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	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 WATER HEATER	2002	\$ 4,864	\$ 177	27.5	\$ 177	\$	\$ 1,689	37
38 NEW PIPE	2002	1,575	57	27.5	57		544	38
39 VINYL FLOORING	2002	17,779		5			17,779	39
40 HANDRAILS,BUMPERS,CORNER	2003	17,903	651	27.5	651		5,561	40
41 SMOKE DAMPERS	2003	1,904	69	27.5	69		589	41
42 DOOR ALARM SYSTEM	2003	3,097	113	27.5	113		965	42
43 SMOKING PORCH	2003	764	28	27.5	28		239	43
44 WALLCOVERINGS & PAINTING	2003	26,197		5			26,197	44
45 DIALYSIS ROOM	2004	23,267	846	27.5	846		6,380	45
46 VALVE ACTUATOR	2004	3,240	118	27.5	118		831	46
47 HOT WATER HEATER	2004	6,837	248	27.5	248		1,746	47
48 CURTAINS	2005	1,513		5			1,513	48
49 FIRE ALARM SYSTEM	2005	4,026	146	27.5	146		955	49
50 SPRINKLER HEADS	2005	2,530	92	27.5	92		602	50
51 FIRE DOOR	2005	547	20	27.5	20		131	51
52 ASPHALT	2005	6,000	400	15	400		2,617	52
53 ELEVATOR EMERGENCY STOP SWITCH	2006	1,849	67	27.5	67		371	53
54 PARKING LOT	2007	26,200	1,747	15	1,747		7,789	54
55 BOILER	2007	4,245	154	27.5	154		687	55
56 WATER HEATER	2007	6,453	235	27.5	235		1,047	56
57 NURSE CALL SYSTEM	2007	2,536	92	27.5	92		410	57
58 A/C CONDENSER	2007	5,928	216	27.5	216		963	58
59 5 TON A/C	2007	3,000	109	27.5	109		486	59
60 BLACK TOP AND SEAL THE PARKING LOT	2008	10,700	713	15	713		2,228	60
61 ROOF	2008	3,800	137	27.5	137		474	61
62 GENERATOR REPAIR	2008	4,578	168	27.5	168		581	62
63 EJECTOR PUMP	2009	3,125	114	27.5	114		280	63
64 CUSTOM CABINETS IN PT ROOM	2009	8,200	298	27.5	298		732	64
65 GENERATOR PANELS	2009	4,297	156	27.5	156		384	65
66 DISTRIBUTION PANEL	2010	9,758	355	27.5	355		517	66
67 WATER MAIN	2010	3,527	128	27.5	128		187	67
68 DOORS	2011	7,939	108	27.5	108		108	68
69 SPRINKLER SYSTEM	2011	5,285	56	27.5	56		56	69
70 TOTAL (lines 4 thru 69)		\$ 390,271	\$ 13,192		\$ 13,192	\$	\$ 148,107	70

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

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward	\$ 390,271	\$ 13,192		\$ 13,192	\$	\$ 148,107	1
2	GENERATOR	2011	59,196	269	27.5	269	269	2
3	CURTAINS & BLINDS	2011	14,987	14,987	5	1,499	(13,488)	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 464,454	\$ 28,448		\$ 14,960	\$ (13,488)	\$ 149,875	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 189,643	\$ 7,502	\$ 18,890	\$ 11,388	10 YRS	\$ 106,955	71
72	Current Year Purchases	3,163	3,163	158	(3,005)	10 YRS	158	72
73	Fully Depreciated Assets	144,885					144,885	73
74								74
75	TOTALS	\$ 337,691	\$ 10,665	\$ 19,048	\$ 8,383		\$ 251,998	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)	\$ 802,145	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,113	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 34,008	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,105)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 401,873	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: ELGIN NURSING HOME PROPERTY
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:		102		\$ 464,280			3
4	Additions							4
5								5
6								6
7	TOTAL		102		\$ 464,280			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: \$ 32,576
- 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	\$ 464,280
13.	/2013	\$ 464,280
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.)

	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	39-3	hrs	\$		\$ 119,409	\$		\$ 119,409	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			70,993			70,993	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			368,235			368,235	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				248,078		248,078	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology, Laboratory, I.V. Therapy Other (specify): Med. Supplies					107,908	3,652		111,560	13
14	TOTAL			\$		\$ 666,545	\$ 251,730		\$ 918,275	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 174,277	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (35,000))	1,905,322		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,830		6
7	Other Prepaid Expenses	4,454		7
8	Accounts Receivable (owners or related parties)	398,253		8
9	Other(specify): Real Estate Escrow Deposit	4,934		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,519,070	\$	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	464,454		15
16	Equipment, at Historical Cost	337,691		16
17	Accumulated Depreciation (book methods)	(492,327)		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	16,895		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 326,713	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,845,783	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,870,438	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	239,954		29
30	Accrued Salaries Payable	142,857		30
31	Accrued Taxes Payable (excluding real estate taxes)	344,649		31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,520		32
33	Accrued Interest Payable	5,384		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)	\$ 2,659,802	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	877,381		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)	\$ 877,381	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,537,183	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (691,400)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,845,783	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,057,981)	1
2	Restatements (describe):		2
3		1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,057,980)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	417,422	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	(50,842)	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)	\$ 366,580	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)	\$ (691,400)	24

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,633,604	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,633,604	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	243,977	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 243,977	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***	1,740	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,740	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)	\$ 6,879,321	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,230,255	31
32	Health Care	2,182,855	32
33	General Administration	1,411,719	33
	B. Capital Expense		
34	Ownership	605,239	34
	C. Ancillary Expense		
35	Special Cost Centers	918,275	35
36	Provider Participation Fee	134,178	36
	D. Other Expenses (specify):		
37	<u>OUT-OF-PERIOD EXPENSES</u>	(20,622)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,461,899	40
41	Income before Income Taxes (line 30 minus line 40)**	417,422	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 417,422	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	1,975	2,151	\$ 94,114	\$ 43.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,999	10,530	335,617	31.87	3
4	Licensed Practical Nurses	12,935	14,728	433,327	29.42	4
5	CNAs & Orderlies	52,145	56,053	650,418	11.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,757	4,396	140,121	31.87	8
9	Activity Director	2,028	2,335	46,387	19.87	9
10	Activity Assistants	7,318	8,154	82,195	10.08	10
11	Social Service Workers	3,784	4,234	112,595	26.59	11
12	Dietician					12
13	Food Service Supervisor	2,030	2,294	57,660	25.14	13
14	Head Cook	11,707	13,280	188,412	14.19	14
15	Cook Helpers/Assistants	5,113	5,449	53,986	9.91	15
16	Dishwashers					16
17	Maintenance Workers	2,070	2,389	61,652	25.81	17
18	Housekeepers	21,083	23,698	279,284	11.79	18
19	Laundry	7,217	7,692	80,202	10.43	19
20	Administrator	2,086	2,086	129,670	62.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,281	7,992	163,533	20.46	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	1,901	2,134	43,598	20.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,429	169,595	\$ 2,952,771 *	\$ 17.41	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	\$ 8,777	1-3	35
36	Medical Director	O	9,000	9-3	36
37	Medical Records Consultant	N	784	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,280	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	7,060	12-3	45
46	Other(specify) <u>Social Rehab</u>	S	4,324	12-3	46
47	<u>Rehabilitation</u>		649	10a-3	47
48	<u>Social Worker</u>		2,736	12-3	48
49	TOTAL (lines 35 - 48)		\$ 38,610		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
JACOB SIEGEL	ADMINISTRATOR	0	\$ 129,670	Workers' Compensation Insurance	\$	64,358	IDPH License Fee	\$ 3,980
	ASST ADMIN		0	Unemployment Compensation Insurance		63,707	Advertising: Employee Recruitment	313
			0	FICA Taxes		224,163	Health Care Worker Background Check	330
				Employee Health Insurance		26,755	(Indicate # of checks performed 10)	
				Employee Meals		0	Patient Background Checks	124 1,228
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	3,149
				EMPLOYEE BENEFITS - OTHER		0	MARKETING/ADV/PROMO	6,851
				EMPLOYEE PHYSICAL EXAMS		2,350	LICENSES/DUES/SUBSCRIPTIONS	6,608
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOC	396
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(3,149)
(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	(6,851)
Description			Amount				Yellow page advertising	(0)
ASTA HEALTHCARE MANAGEMENT, INC			\$ 290,000					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,	\$	381,333	TOTAL (agree to Sch. V,	
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								3,668
							MARKETING TRAVEL	(1,637)
							Seminar Expense	
								0
SEE SCHEDULE ATTACHED			91,926				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)							line 24, col. 8)	\$ 2,031
			\$ 91,926					

* 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 ASSOCIATES \$ 6,335
- (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.

\$ 29,025

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

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

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.

\$ 134,178

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.