

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0045823

Facility Name: ASTA CARE CTR - FORD COUNTY

Address: 1240 N MARKET ST PAXTON 60957
Number City Zip Code

County: FORD

Telephone Number: (847) 742-8822- Fax # (847) 742-9013

HFS ID Number:

Date of Initial License for Current Owners: 07/01/02

Type of Ownership:

☐ 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	

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR Telephone Number: (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	MICHAEL GILLMAN	
	(Title)	MEMBER	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
		(Date)	
	(Print Name and Title)	SANFORD BOKOR PRESIDENT	
	(Firm Name & Address)	KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	(847) 675-3585 Fax # (847) 675-5777	
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

Facility Name & ID Number ASTA CARE CTR - FORD COUNTY# 0045823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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>25,254</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>25,254</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>143</u>	<u>30</u>	<u>2,155</u>	<u>2,328</u>	8
9	SNF/PED					9
10	ICF	<u>17,312</u>	<u>2,072</u>	<u>494</u>	<u>19,878</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,455</u>	<u>2,102</u>	<u>2,649</u>	<u>22,206</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.93%

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?

YESG. 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 07/01/02

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

YES ☒Date 07/02/02NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 51 and days of care provided 2,102Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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	191,478	19,666	18,879	230,023		230,023		230,023			1
2	Food Purchase		142,658		142,658		142,658	(1,674)	140,984			2
3	Housekeeping	170,305	21,240		191,545		191,545		191,545			3
4	Laundry	2,381	9,536	1,478	13,395		13,395		13,395			4
5	Heat and Other Utilities			55,801	55,801		55,801		55,801			5
6	Maintenance	37,549	14,735	34,169	86,453		86,453	42	86,495			6
7	Other (specify):*			9,929	9,929		9,929		9,929			7
8	TOTAL General Services	401,713	207,835	120,256	729,804		729,804	(1,632)	728,172			8
	B. Health Care and Programs											
9	Medical Director			8,250	8,250		8,250		8,250			9
10	Nursing and Medical Records	1,110,806	95,737	9,469	1,216,012		1,216,012	9,941	1,225,953			10
10a	Therapy		3,592		3,592		3,592		3,592			10a
11	Activities	68,067	4,957		73,024		73,024		73,024			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,178,873	104,286	17,719	1,300,878		1,300,878	9,941	1,310,819			16
	C. General Administration											
17	Administrative	77,841		225,000	302,841		302,841	(72,704)	230,137			17
18	Directors Fees											18
19	Professional Services			82,418	82,418		82,418	(5,348)	77,070			19
20	Dues, Fees, Subscriptions & Promotions			17,861	17,861		17,861	(6,874)	10,987			20
21	Clerical & General Office Expenses	76,961	19,199	104,854	201,014		201,014	(47,864)	153,150			21
22	Employee Benefits & Payroll Taxes			259,890	259,890		259,890		259,890			22
23	Inservice Training & Education			1,448	1,448		1,448	96	1,544			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			14,777	14,777		14,777	(2,590)	12,187			25
26	Insurance-Prop.Liab.Malpractice			49,032	49,032		49,032	151	49,183			26
27	Other (specify):*			120,667	120,667		120,667	(114,963)	5,704			27
28	TOTAL General Administration	154,802	19,199	875,947	1,049,948		1,049,948	(250,096)	799,852			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,735,388	331,320	1,013,922	3,080,630		3,080,630	(241,787)	2,838,843			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	5,543
	REPAIRS & MAINTENANCE		13,336
			0
			18,879
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		1,478
			0
			1,478
5	HEAT & OTHER UTILITIES		
	GAS HEAT		16,634
	ELECTRICITY		30,838
	WATER		7,790
	CABLE TV - LOBBY		539
			0
			55,801
6	MAINTENANCE		
	GROUNDS MAINTENANCE		4,786
	PAINTING & DECORATING		0
	BUILDING REPAIRS		1,782
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		23,021
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		1,795
	FIRE SERVICE		2,785
			0
			0
			0
			0
			34,169
7	OTHER		
	SCAVENGER		9,929
	SECURITY SERVICE		0
			0
			0
			9,929
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,250
			8,250

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		1,070
	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	1,170
	PHARMACY CONSULTANT	XVIII B 39-2	6,428
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	801
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			9,469
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	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
		0	
17	ADMINISTRATIVE		
	MANAGEMENT FEES XIX B	225,000	225,000
	DIRECTORS FEES		
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING XIX C	21,855	
	ADMINISTRATIVE CONSULTANTS XIX C	0	
	PROFESSIONAL FEES XIX C	60,563	
		0	82,418
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,236	
	EMPLOYEE WANT ADS XIX F	1,960	
	CONTRIBUTIONS VI 20 XIX F	3,250	
	DUES & SUBSCRIPTIONS XIX F	2,711	
	LICENSES & PERMITS XIX F	3,948	
	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	630	
	PATIENT BACKGROUND CHECKS XIX F	983	
			17,861
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	13,546	
	EQUIPMENT REPAIR & MAINTENANCE	2,754	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES VI 18	73,285	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	15,269	
	MESSENGER SERVICE	0	
		0	104,854

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES XIX D	129,627	
	UNEMPLOYMENT COMPENSATION XIX D	68,548	
	WORKERS COMPENSATION INSURANC XIX D	49,274	
	HOSPITALIZATION INSURANCE XIX D	11,059	
	EMPLOYEE BENEFITS - OTHER XIX D	616	
	EMPLOYEE PHYSICAL EXAMS XIX D	766	
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS XIX D	0	
	CHICAGO HEAD TAX XIX D	0	
		0	259,890
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	1,448	
			1,448
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS XIX G	0	
	TRAVEL XIX G	0	
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	14,777	
			14,777
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	49,032	
			49,032
27	OTHER		
	BAD DEBTS VI 24	120,667	
			120,667

GRAND TOTAL COLUMN 3 OTHER

1,013,922

ASTA CARE CTR - FORD COUNTY
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	142,658
LESS SALES TAX	<u>(1,674)</u>
NET FOOD	140,984
TOTAL PATIENT CENSUS	22,206
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	66,618
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	66,618
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	66,618
NET FOOD	140,984
DIVIDE TOTAL MEALS/YEAR	<u>66,618</u>
COST PER MEAL	2.12
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

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			7,602	7,602		7,602	56,318	63,920			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,295	56,295		56,295	65,795	122,090			32
33	Real Estate Taxes			28,428	28,428		28,428		28,428			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles			17,007	17,007		17,007		17,007			35
36	Other (specify):*			931	931		931		931			36
37	TOTAL Ownership			290,263	290,263		290,263	(57,887)	232,376			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		82,716	263,775	346,491		346,491	5,856	352,347			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			158,231	158,231		158,231		158,231			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		82,716	422,006	504,722		504,722	5,856	510,578			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,735,388	414,036	1,726,191	3,875,615		3,875,615	(293,818)	3,581,797			45

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

Facility Name & ID Number ASTA CARE CTR - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012
VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,192	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,674)	2		13
14	Non-Care Related Interest	(4,648)	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	(73,285)	21		18
19	Entertainment		20		19
20	Contributions	(4,393)	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	(120,667)	27		24
25	Fund Raising, Advertising and Promotional	(3,236)	20		25
	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	(19,268)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (225,979)		\$	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)	(67,839)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (67,839)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (293,818)		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 CTR - FORD COUNTY

Page 5A

ID# 0045823
Report Period Beginning: 01/01/2012
Ending: 12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	MARKETING SALARY	\$ (8,846)	21	1
2	STAFF TRANSPORTATION - MARKETING	(9,547)	25	2
3	RELATED PARTY THERAPY ADJUSTMENT	5,856	39	3
4	NON ALLOWABLE PROFESSIONAL FEES	(6,731)	19	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	(19,268)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CTR - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,674)	0	0	0	0	0	0	0	0	0	0	(1,674)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	42	0	0	0	0	0	0	0	0	0	42	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,674)	42	0	0	0	0	0	0	0	0	0	(1,632)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	9,941	0	0	0	0	0	0	0	0	0	9,941	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	9,941	0	0	0	0	0	0	0	0	0	9,941	16
	C. General Administration													
17	Administrative	0	(72,704)	0	0	0	0	0	0	0	0	0	(72,704)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,731)	1,383	0	0	0	0	0	0	0	0	0	(5,348)	19
20	Fees, Subscriptions & Promotions	(7,629)	755	0	0	0	0	0	0	0	0	0	(6,874)	20
21	Clerical & General Office Expenses	(82,131)	34,267	0	0	0	0	0	0	0	0	0	(47,864)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	96	0	0	0	0	0	0	0	0	0	96	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(9,547)	6,957	0	0	0	0	0	0	0	0	0	(2,590)	25
26	Insurance-Prop.Liab.Malpractice	0	151	0	0	0	0	0	0	0	0	0	151	26
27	Other (specify):*	(120,667)	5,704	0	0	0	0	0	0	0	0	0	(114,963)	27
28	TOTAL General Administration	(226,705)	(23,391)	0	0	0	0	0	0	0	0	0	(250,096)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(228,379)	(13,408)	0	0	0	0	0	0	0	0	0	(241,787)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	1,192	0	55,126	0	0	0	0	0	0	0	0	56,318	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,648)	0	70,443	0	0	0	0	0	0	0	0	65,795	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(180,000)	0	0	0	0	0	0	0	0	(180,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,456)	0	(54,431)	0	0	0	0	0	0	0	0	(57,887)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	5,856	0	0	0	0	0	0	0	0	0	0	5,856	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	5,856	0	0	0	0	0	0	0	0	0	0	5,856	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(225,979)	(13,408)	(54,431)	0	0	0	0	0	0	0	0	(293,818)	45

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
MICHAEL GILLMAN	60	ASTA CARE CENTER OF BLOOMINGTON	BLOOMINGTON	ASTA		
DARRYLE GILLMAN	10	ASTA CARE CENTER OF COLFAX	COLFAX	HEALTHCARE CO.	ELGIN	MANAGEMENT
SETH GILLMAN	10	ASTACARE CENTER OF ELGIN	ELGIN			
DAVID MEISELMAN	10	ASTA CARE CENTER OF PONTIAC	PONTIAC			
CRAIG FRANK	10	ASTA CARE CENTER OF ROCKFORD	ROCKFORD	ASTA THERAPY		THERAPY
		ASTA CARE CENTER OF TOLUCA	TOLUCA	ASTA PAXTON		REAL ESTATE
				PROPERTIES		

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	\$ 120,000	ASTA HEALTHCARE COMPANY, INC.		\$	\$ (120,000)	1
2	V	6	MAINTENANCE		ASTA HEALTHCARE COMPANY, INC.		42	42	2
3	V	10	NURSING		ASTA HEALTHCARE COMPANY, INC.		9,941	9,941	3
4	V	17	ADMINISTRATIVE		ASTA HEALTHCARE COMPANY, INC.		47,296	47,296	4
5	V	19	PROFESSIONAL FEES		ASTA HEALTHCARE COMPANY, INC.		1,383	1,383	5
6	V	20	LICENSES & PERMITS		ASTA HEALTHCARE COMPANY, INC.		755	755	6
7	V	21	OFFICE EXPENSE		ASTA HEALTHCARE COMPANY, INC.		34,267	34,267	7
8	V	23	SEMINARS		ASTA HEALTHCARE COMPANY, INC.		96	96	8
9	V	25	STAFF TRANS/TRAVEL		ASTA HEALTHCARE COMPANY, INC.		6,957	6,957	9
10	V	26	GENERAL INSURANCE		ASTA HEALTHCARE COMPANY, INC.		151	151	10
11	V	27	PAYR. TAXES & W/C		ASTA HEALTHCARE COMPANY, INC.		5,704	5,704	11
12	V								12
13	V								13
14	Total			\$ 120,000			\$ 106,592	\$ * (13,408)	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		\$	(180,000)	15
16	V	30	DEPRECIATION				55,126	55,126	16
17	V	32	AMORT LOAN COSTS				6,018	6,018	17
18	V	32	INTEREST				64,425	64,425	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			\$ 125,569	\$ * (54,431)	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 CTR - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	\$ 23,560	17-7	1
2			management								2
3	CRAIG FRANK	CFO	finance manage.	10.00	SEE	SEE		SALARY	19,731	17-7	3
4					ATTACHED	ATTACHED		MGMNT			4
5	MANAGEMENT FEE FROM ASTA CARE OF FORD COUNTY \$105,000				SCHEDULE	SCHEDULE		FEE	105,000	17-3	5
6	MANAGEMENT FEE FROM ASTA CARE OF COLFAX \$30,000				SCHEDULE						6
7											7
8	ALIZA FRANK	PAYROLL CLERK	PAYROLL					SALARY	4,005	17-7	8
9	DAVID MEISELMAN	THERAPY MGMNT	management	10.00				SALARY	35,753	17-7	9
10											10
11											11
12								SALARY			12
13								TOTAL	\$ 188,049		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

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PATIENT DAYS	188,506	7	\$ 353	\$	22,206	\$ 42	1
2	10	NURSING	PATIENT DAYS	188,506	7	84,392	84,265	22,206	9,941	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	188,506	7	200,000	200,000	22,206	23,560	3
4	17	ADMIN. SALARY -CF	PATIENT DAYS	188,506	7	167,500	167,500	22,206	19,731	4
5	17	ADMIN. SALARY -AF	PATIENT DAYS	188,506	7	34,000	34,000	22,206	4,005	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	188,506	7	11,736		22,206	1,383	6
7	20	LICENSES & PERMITS	PATIENT DAYS	188,506	7	6,406		22,206	755	7
8	21	OFFICE EXPENSE	PATIENT DAYS	188,506	7	290,893	229,289	22,206	34,267	8
9	23	SEMINARS	PATIENT DAYS	188,506	7	815		22,206	96	9
10	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	188,506	7	59,054		22,206	6,957	10
11	26	GENERAL INSURANCE	PATIENT DAYS	188,506	7	1,282		22,206	151	11
12	27	PAYR. TAXES & W/C	PATIENT DAYS	188,506	7	48,417		22,206	5,704	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					\$ 904,848	\$ 715,054		\$ 106,592	25

Facility Name & ID Number	ASTA CARE CTR - FORD COUNTY
--------------------------------------	------------------------------------

0045823

Report Period Beginning:

01/01/2012

Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number**Fax Number**

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

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				846,666				64,425	2	
3	LOAN COSTS		X	LOAN COSTS			30,092	3,512				6,018	3	
4	MEMBER LOAN			WORKING CAPITAL								2,512	4	
5	CATERPILLAR		X	GENERATOR PURCH	\$438.00			4,666	7/14/15	0.0560		520	5	
	Working Capital													
6	COLE TAYLOR BABK		X	WORKING CAPITAL					REVOLV			39,855	6	
7	INSURANCE POLICIES		X	INS POLICY FINANCE								1,090	7	
8	MIDCAP FINANCIAL			L.O.C.					REVOLV			4,679	8	
9	TOTAL Facility Related				\$438.00		\$ 30,092	\$ 854,844			\$ 119,099	9		
	B. Non-Facility Related*													
10	IRS											1,812	10	
11	Healthcare Family Services		X	BED TAX								2,836	11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	\$			\$ 4,648	14		
15	TOTALS (line 9+line14)						\$ 30,092	\$ 854,844			\$ 123,747	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 2011 report.	\$	27,886		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.)	\$	28,157		2	
3. Under or (over) accrual (line 2 minus line 1).	\$	271		3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	28,157		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.	\$	28,428		7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	30,473	8		
	2008	32,210	9		
	2009	32,296	10		
	2010	27,886	11		
	2011	28,157	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 2011 TAX BILL.					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$
14	PLUS APPEAL COST FROM LINE 5	\$
15	LESS REFUND FROM LINE 6	\$
16	AMOUNT TO USE FOR RATE CALCULATION	\$

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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

ASTA CARE CTR - FORD COUNTY

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 2011 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 2011.

	(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.	11-14-05-300-007	NURSING HOME	\$ 28,157.46	\$ 28,157.46
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 28,157.46	\$ 28,157.46

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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?

X

(a) Own the Facility

(b) Rent from a Related Organization.

X

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X

(c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			2008	\$ 125,000	1
2					2
3	TOTALS			\$ 125,000	3

Facility Name & ID Number ASTA CARE CTR - FORD COUNTY

0045823

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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		\$ 160,861
5										
6										
7										
8										
	Improvement Type**									
9	NURSE STATION			2002	10,000	364	27.5	364		3,776
10	ROOF			2002	28,434	1,034	27.5	1,034		10,728
11	NURSE STATION			2002	10,000	363	27.5	363		3,766
12	ROOF			2004	31,800	1,156	27.5	1,156		10,356
13	ELECTRICAL WORK			2005	3,959	144	27.5	144		1,086
14	SECURITY SYSTEM			2005	35,650	1,296	27.5	1,296		11,681
15	ASPHALT SIDEWALK			2005	2,200	147	15	147		1,084
16	10 TON PKG UNIT			2006	8,500	309	27.5	309		1,944
17	EMERGENCY SWITCH PANEL			2006	1,828	66	27.5	66		415
18	TILING			2006	1,091	40	27.5	40		252
19	WATER HEATER			2007	8,943	325	27.5	325		1,855
20	WATER MAIN WORK			2007	6,857	457	15	457		2,342
21	FLOORING			2007	11,440	659	5	659		10,955
22	DRAIN REPAIR (REL PARTY)			2008	8,612	313	27.5	313		1,422
23	FLOORING (REL PARTY)			2008	2,539	92	27.5	92		395
24	GENERATOR (REL PARTY)			2008	6,569	239	27.5	239		986
25	ELECTRICAL WORK (REL PARTY)			2009	4,395	160	27.5	160		580
26	WATER HEATER (REL PARTY)			2009	10,765	391	27.5	391		1,417
27	GENERATOR (REL PARTY)			2010	29,504	1,072	27.5	1,072		3,173
28	TILING (REL PARTY)			2010	3,426	125	27.5	125		368
29	CONCRETE RAMP(REL PARTY)			2010	3,000	200	15	200		500
30	ROOFTOP PACKAGE A/C WITH GAS HEAT (REL PARTY)			2011	8,135	296	27.5	296		432
31	WATER HEATER (REL PARTY)			2012	9,000	259	27.5	259		259
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)		\$1,238,862	\$45,588		\$45,588	\$	\$230,633	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	\$ 1,242	\$ 4,532	\$ 3,290	10 YRS	\$ 31,673	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	REL PARTY	138,000	15,898	13,800	(2,098)	10 YRS	62,100	74
75	TOTALS	\$ 186,804	\$ 17,140	\$ 18,332	\$ 1,192		\$ 93,773	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	\$	\$	\$		\$ 16,290	76
77										77
78										78
79										79
80	TOTALS			\$ 16,288	\$	\$	\$		\$ 16,290	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,566,954	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 62,728	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,920	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,192	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 340,696	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:				\$ 180,000			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 180,000			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?
16. Rental Amount for movable equipment: \$ 17,007 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☒ NO

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. /2013 \$
13. /2014 \$
14. /2015 \$

* 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.

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		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	\$		\$ 62,854	\$		\$ 62,854	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			5,797			5,797	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits			186,028			186,028	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				82,623		82,623	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	laboratory,med. Supplies, i.v. therapy, Other (specify): other services	39-8				9,096	93		9,189	13
14	TOTAL			\$		\$ 263,775	\$ 82,716		\$ 346,491	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	\$ 7,624	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (56,000))	1,392,645		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,154		6
7	Other Prepaid Expenses	9,366		7
8	Accounts Receivable (owners or related parties)	92,220		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,532,009	\$	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)	(125,012)		17
18	Deferred Charges	32,573		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Dept. on Fixed Assets	117,375		22
23	Other(specify): Security Deposits	431		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 251,161	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,783,170	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,712,141	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	60,423		29
30	Accrued Salaries Payable	44,248		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,224		31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,157		32
33	Accrued Interest Payable	4,679		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)	\$ 1,859,872	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	377,354		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)	\$ 377,354	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,237,226	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (454,056)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,783,170	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (355,263)	1
2	Restatements (describe):		2
3	POST CLOSING ENTRIES	(72,385)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (427,648)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(26,408)	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)	\$ (26,408)	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)	\$ (454,056)	24 *

* This must agree with page 17, line 47.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,718,210	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,718,210	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,997	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 130,997	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 3,849,207	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	729,804	31
32	Health Care	1,300,878	32
33	General Administration	1,049,948	33
B. Capital Expense			
34	Ownership	290,263	34
C. Ancillary Expense			
35	Special Cost Centers	346,491	35
36	Provider Participation Fee	158,231	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,875,615	40
41	Income before Income Taxes (line 30 minus line 40)**	(26,408)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (26,408)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,405,465	44
45	Private Pay - Net Inpatient Revenue	366,526	45
46	Medicare - Net Inpatient Revenue	834,806	46
47	Other-(specify) <u>INSURANCE</u>	111,413	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,718,210	49

**TAX RETURN PREPARED ON CASH BASIS

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

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	1,866	1,985	\$ 57,054	\$ 28.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,579	3,019	73,442	24.33	3
4	Licensed Practical Nurses	16,358	18,049	389,299	21.57	4
5	CNAs & Orderlies	48,874	52,984	562,148	10.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,988	2,013	35,931	17.85	9
10	Activity Assistants	2,895	3,209	32,136	10.01	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,478	1,521	27,509	18.09	13
14	Head Cook	3,789	4,101	48,833	11.91	14
15	Cook Helpers/Assistants	11,179	12,982	115,136	8.87	15
16	Dishwashers					16
17	Maintenance Workers	1,874	2,114	37,549	17.76	17
18	Housekeepers	15,274	17,195	170,305	9.90	18
19	Laundry	209	250	2,381	9.52	19
20	Administrator	2,107	2,251	77,841	34.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,198	4,474	76,961	17.20	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	1,952	2,150	28,863	13.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	116,620	128,297	\$ 1,735,388 *	\$ 13.53	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 5,543	1-3	35
36	Medical Director	O	8,250	9-3	36
37	Medical Records Consultant	N	1,170	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,428	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	801	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,192		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

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

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. _____

(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. \$ 29,767 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. \$ 158,231
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.