FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0045823

Facility Name: ASTA CARE CENTER - FORD COUNTY

Address: 1240 NORTH MARKET STREET (Number) PAXTON (City) 60957 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **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 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MICHAEL GILLMAN
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE 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 CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	69	Skilled (SNF)	69	25,185	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	69	TOTALS	69	25,185	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,386	266	1,880	3,532	8
9	SNF/PED					9
10	ICF	16,370	2,669	397	19,436	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,756	2,935	2,277	22,968	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.20%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07/01/02

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/02/02 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 51 and days of care provided 1,837

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	202,291	12,094	6,603	220,988		220,988		220,988			1
2	Food Purchase		125,506		125,506		125,506	(764)	124,742			2
3	Housekeeping	152,316	17,395		169,711		169,711		169,711			3
4	Laundry	3,467	10,671		14,138		14,138		14,138			4
5	Heat and Other Utilities			89,493	89,493		89,493		89,493			5
6	Maintenance	39,725	14,166	14,940	68,831		68,831		68,831			6
7	Other (specify):*			7,463	7,463		7,463		7,463			7
8	TOTAL General Services	397,799	179,832	118,499	696,130		696,130	(764)	695,366			8
	B. Health Care and Programs											
9	Medical Director			11,250	11,250		11,250		11,250			9
10	Nursing and Medical Records	1,017,696	92,642	20,543	1,130,881	6,152	1,137,033	6,321	1,143,354			10
10a	Therapy		13,983		13,983		13,983		13,983			10a
11	Activities	74,515	7,764		82,279		82,279		82,279			11
12	Social Services	6,108			6,108		6,108		6,108			12
13	CNA Training											13
14	Program Transportation			624	624		624		624			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,098,319	114,389	32,417	1,245,125	6,152	1,251,277	6,321	1,257,598			16
	C. General Administration											
17	Administrative	118,776		170,000	288,776		288,776	(79,748)	209,028			17
18	Directors Fees											18
19	Professional Services			59,906	59,906	(6,152)	53,754	432	54,186			19
20	Dues, Fees, Subscriptions & Promotions			17,867	17,867		17,867	(10,151)	7,716			20
21	Clerical & General Office Expenses	70,749	21,818	58,682	151,249		151,249	(22,466)	128,783			21
22	Employee Benefits & Payroll Taxes			271,970	271,970		271,970		271,970			22
23	Inservice Training & Education			1,896	1,896		1,896		1,896			23
24	Travel and Seminar							312	312			24
25	Other Admin. Staff Transportation			12,142	12,142		12,142	(3,467)	8,675			25
26	Insurance-Prop.Liab.Malpractice			42,480	42,480		42,480	952	43,432			26
27	Other (specify):*			53,359	53,359		53,359	(47,099)	6,260			27
28	TOTAL General Administration	189,525	21,818	688,302	899,645	(6,152)	893,493	(161,235)	732,258			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,685,643	316,039	839,218	2,840,900		2,840,900	(155,678)	2,685,222			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: ASTA CARE CENTER - FORD COUNTY #0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,467	
	REPAIRS & MAINTENANCE		2,136	
			0	6,603
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		8,278	
	ELECTRICITY		35,695	
	WATER		45,213	
	CABLE TV - LOBBY		307	
			0	89,493
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,201	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,136	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,425	
	FIRE SERVICE		2,178	
			0	
			0	
			0	
			0	14,940
7	**OTHER**			
	SCAVENGER		7,463	
	SECURITY SERVICE		0	
			0	
			0	7,463
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	11,250	11,250

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 CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	3,343	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	17,200	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	20,543
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY **#0045823** **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		624	624
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	170,000	170,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,245	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	44,661	
			0	59,906
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	6,375	
	EMPLOYEE WANT ADS	XIX F	981	
	CONTRIBUTIONS	VI 20 XIX F	3,300	
	DUES & SUBSCRIPTIONS	XIX F	2,728	
	LICENSES & PERMITS	XIX F	1,883	
	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	1,100	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	450	
	PATIENT BACKGROUND CHECKS	XIX F	1,050	
				17,867
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		7,310	
	EQUIPMENT REPAIR & MAINTENANCE		262	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	34,526	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,584	
	MESSENGER SERVICE		0	
			0	58,682

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	118,278	
	UNEMPLOYMENT COMPENSATION	XIX D	24,778	
	WORKERS COMPENSATION INSURANC	XIX D	91,996	
	HOSPITALIZATION INSURANCE	XIX D	34,713	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,205	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	271,970
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,896	
				1,896
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		12,142	
				12,142
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		42,480	
				42,480
27	**OTHER**			
	BAD DEBTS	VI 24	53,359	
				53,359

GRAND TOTAL COLUMN 3 OTHER **839,218**

ASTA CARE CENTER - FORD COUNTY
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	125,506
LESS SALES TAX	(764)
NET FOOD	124,742
TOTAL PATIENT CENSUS	22,968
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	68,904
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	68,904
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	68,904
NET FOOD	124,742
DIVIDE TOTAL MEALS/YEAR	68,904
COST PER MEAL	1.81
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY #0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			13,854	13,854		13,854	54,417	68,271			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,451	36,451		36,451	75,296	111,747			32
33	Real Estate Taxes			32,001	32,001		32,001		32,001			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles			23,285	23,285		23,285		23,285			35
36	Other (specify):*											36
37	**TOTAL Ownership**			285,591	285,591		285,591	(50,287)	235,304			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		62,653	364,586	427,239		427,239		427,239			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,778	37,778		37,778		37,778			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		62,653	402,364	465,017		465,017		465,017			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,685,643	378,692	1,527,173	3,591,508		3,591,508	(205,965)	3,385,543			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 CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,602)	30		9
10	Interest and Other Investment Income	(6,496)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(764)	2		13
14	Non-Care Related Interest	(4,009)	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	(34,526)	21		18
19	Entertainment		20		19
20	Contributions	(4,400)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(309)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,359)	27		24
25	Fund Raising, Advertising and Promotional	(6,375)	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	(22,817)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (143,657)		$	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)	(62,308)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (62,308)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (205,965)		37

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

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

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

STATE OF ILLINOIS

ASTA CARE CENTER - FORD COUNTY

ID# 0045823

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	MARKETING SALARY	(1,363)	21	2
3	NON ALLOWABLE TRAVEL	(8,482)	25	3
4	MARKETING SALARY	(12,972)	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**	(22,817)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY **#** 0045823 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(764)	0	0	0	0	0	0	0	0	0	0	(764)	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	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(764)	0	0	0	0	0	0	0	0	0	0	(764)	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	6,321	0	0	0	0	0	0	0	0	0	6,321	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	6,321	0	0	0	0	0	0	0	0	0	6,321	16
	C. General Administration													
17	Administrative	0	(79,748)	0	0	0	0	0	0	0	0	0	(79,748)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(309)	741	0	0	0	0	0	0	0	0	0	432	19
20	Fees, Subscriptions & Promotions	(10,775)	624	0	0	0	0	0	0	0	0	0	(10,151)	20
21	Clerical & General Office Expenses	(48,861)	26,395	0	0	0	0	0	0	0	0	0	(22,466)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	312	0	0	0	0	0	0	0	0	0	312	24
25	Other Admin. Staff Transportation	(8,482)	5,015	0	0	0	0	0	0	0	0	0	(3,467)	25
26	Insurance-Prop.Liab.Malpractice	0	952	0	0	0	0	0	0	0	0	0	952	26
27	Other (specify):*	(53,359)	6,260	0	0	0	0	0	0	0	0	0	(47,099)	27
28	**TOTAL General Administration**	(121,786)	(39,449)	0	0	0	0	0	0	0	0	0	(161,235)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(122,550)	(33,128)	0	0	0	0	0	0	0	0	0	(155,678)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(10,602)	0	65,019	0	0	0	0	0	0	0	0	54,417	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,505)	0	85,801	0	0	0	0	0	0	0	0	75,296	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**	(21,107)	0	(29,180)	0	0	0	0	0	0	0	0	(50,287)	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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(143,657)	(33,128)	(29,180)	0	0	0	0	0	0	0	0	(205,965)	45

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				ASTA		
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		HEALTHCARE CO.	ELGIN	MANAGEMENT
				ASTA PAXTON	ELGIN	LANDLORD
				PROPERTIES		
				ASTA THERAPY	ELGIN	THERAPY

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 145,000	ASTA HEALTHCARE COMPANY		$	$ (145,000)	1
2	V	10	NURSING				6,321	6,321	2
3	V	17	ADMINISTRATIVE				65,252	65,252	3
4	V	19	PROFESSIONAL FEES				741	741	4
5	V	20	LICENSES & PERMITS				624	624	5
6	V	21	OFFICE EXPENSE				26,395	26,395	6
7	V	24	SEMINARS				312	312	7
8	V	25	STAFF TRANS/ TRAVEL				5,015	5,015	8
9	V	26	INSURANCE GEN / WC				952	952	9
10	V	27	PAYR. TAXES & GRP INS				6,260	6,260	10
11	V								11
12	V								12
13	V								13
14	Total			$ 145,000			$ 111,872	$ * (33,128)	14

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

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 180,000	ASTA PAXTON PROPERTIES, LLC		$	$ (180,000)	15
16	V	30	DEPRECIATION				65,019	65,019	16
17	V	32	INTEREST				85,801	85,801	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 180,000			$ 150,820	$ * (29,180)	39

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

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN							SALARY	$ 24,842	17-7	1
2											2
3											3
4					SEE	SEE					4
5	CRAIG FRANK				ATTACHED	ATTACHED		SALARY	25,399	17-7	5
6	SALARY FROM ASTA CARE OF FORD COUNTY $43,541				SCHEDULE	SCHEDULE		SALARY	43,541	17-1	6
7	MANAGEMENT FEE FROM ASTA CARE OF FORD COUNTY $25,000							SALARY	25,000	17-3	7
8											8
9											9
10											10
11											11
12	ALIZA FRANK		PAYROLL					SALARY	4,512	17-7	12
13								TOTAL	$ 123,294		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 - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	180,290	7	$ 49,619	$ 49,619	22,968	$ 6,321	1
2	17	OFFICER'S SALARY -MG	PATIENT DAYS	180,290	7	195,000	195,000	22,968	24,842	2
3	17	ADMIN. SALARY -CF	PATIENT DAYS	180,290	7	199,375	199,375	22,968	25,399	3
4	17	ADMIN. SALARY -AF	PATIENT DAYS	180,290	7	35,417	35,417	22,968	4,512	4
5	17	ADMIN. SALARY- JS	PATIENT DAYS	180,290	7	82,414	82,414	22,968	10,499	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	180,290	7	5,819		22,968	741	6
7	20	LICENSES & PERMITS	PATIENT DAYS	180,290	7	4,897		22,968	624	7
8	21	OFFICE EXPENSE	PATIENT DAYS	180,290	7	207,187	169,766	22,968	26,395	8
9	24	SEMINARS	PATIENT DAYS	180,290	7	2,453		22,968	312	9
10	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	180,290	7	39,363		22,968	5,015	10
11	26	INSURANCE GEN / WC	PATIENT DAYS	180,290	7	7,472		22,968	952	11
12	27	PAYR. TAXES & GRP INS	PATIENT DAYS	180,290	7	49,140		22,968	6,260	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					$ 878,156	$ 731,591		$ 111,872	25

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION- SL	DIRECT			$	$		$	1
2	32	INTEREST	DIRECT							2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY						$	$			$	1
2	COLE TAYLOR BANK		X	MORTGAGE				1,006,667			79,783	2
3	LOAN COSTS		X	LOAN COSTS	AMORT OVER LIFE OF LOA		30,092	15,548			6,018	3
4												4
5	CATERPILLAR		X	GENERATOR PURCH	$438.00		22,858	21,190	7/14/15	0.0560	523	5
	Working Capital											
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	REVOLV		370,608			24,776	6
7	INSURANCE POLICIES		X	INTEREST ON INSURANCE							4,656	7
8	RELATED PARTIES	X		WORKING CAPITAL							2,487	8
9	TOTAL Facility Related				$438.00		$ 52,950	$ 1,414,013			$ 118,243	9
	B. Non-Facility Related*											
10	IDPA		X	BED TAX							3,778	10
11				MISC							231	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 4,009	14
15	TOTALS (line 9+line14)						$ 52,950	$ 1,414,013			$ 122,252	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.)**

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY **#** 0045823 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 32,591	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.)		$ 32,296	2
3. Under or (over) accrual (line 2 minus line 1).		$ (295)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 32,296	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.		$ 32,001	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	30,272	8
	2006	29,792	9
	2007	30,473	10
	2008	32,210	11
	2009	32,296	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.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER - 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 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-14-05-300-001	NURSING HOME	$ 32,295.50	$ 32,295.50
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 32,295.50	$ 32,295.50

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior BRICK/WOOD Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [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? [ ] (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).

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2008	$ 125,000	1
2					2
3	TOTALS			$ 125,000	3

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	69		2008		$ 992,215	$ 36,081	27.5	$ 36,081	$	$ 88,699	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NURSE STATION			2002	10,000	364	27.5	364		3,048	9
10	ROOF			2002	28,434	1,034	27.5	1,034		8,660	10
11	NURSE STATION			2002	10,000	363	27.5	363		3,040	11
12	ROOF			2004	31,800	1,156	27.5	1,156		8,044	12
13	ELECTRICAL WORK			2005	3,959	144	27.5	144		798	13
14	SECURITY SYSTEM			2005	35,650	1,296	27.5	1,296		9,089	14
15	ASPHALT SIDEWALK			2005	2,200	147	15	147		790	15
16	10 TON PKG UNIT			2006	8,500	309	27.5	309		1,326	16
17	EMERGENCY SWITCH PANEL			2006	1,828	66	27.5	66		283	17
18	TILING			2006	1,091	40	27.5	40		172	18
19	WATER HEATER			2007	8,943	325	27.5	325		1,205	19
20	WATER MAIN WORK			2007	6,857	457	15	457		1,428	20
21	FLOORING			2007	11,440	1,318	5	2,288	970	8,008	21
22	DRAIN REPAIR (REL PARTY)			2008	8,612	313	27.5	313		796	22
23	FLOORING (REL PARTY)			2008	2,539	92	27.5	92		211	23
24	GENERATOR (REL PARTY)			2008	6,569	239	27.5	239		508	24
25	ELECTRICAL WORK (REL PARTY)			2009	4,395	160	27.5	160		260	25
26	WATER HEATER (REL PARTY)			2009	10,765	391	27.5	391		635	26
27	GENERATOR (REL PARTY)			2010	29,504	1,028	27.5	1,028		1,028	27
28	TILING (REL PARTY)			2010	3,426	119	27.5	119		119	28
29	CONCRETE RAMP(REL PARTY)			2010	3,000	100	15	100		100	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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)		$ 1,221,727	$ 45,542		$ 46,512	$ 970	$ 138,247	70

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

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 45,207	$ 3,116	$ 4,521	$ 1,405	10 YRS	$ 22,080	71
72	Current Year Purchases	3,597	2,159	180	(1,979)	10 YRS	180	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	138,000	26,496	13,800	(12,696)	10 YRS	34,500	74
75	TOTALS	$ 186,804	$ 31,771	$ 18,501	$ (13,270)		$ 56,760	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2001 FORD VAN	2005	$ 16,288	$ 1,560	$ 3,258	$ 1,698	5 YRS	$ 13,032	76
77										77
78										78
79										79
80	TOTALS			$ 16,288	$ 1,560	$ 3,258	$ 1,698		$ 13,032	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)	$ 1,549,819	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 78,873	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 68,271	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,602)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 208,039	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.

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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.		$
13.		$
14.		$

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: $ 23,285 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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 86,727	$		$ 86,727	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			30,675			30,675	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			236,300			236,300	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				62,478		62,478	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	inhalation therapy,radiology,lab,i.v.therap Other (specify): medical supplies	39-8 39-8				10,884	175		10,884 175	13
14	TOTAL			$		$ 364,586	$ 62,653		$ 427,239	14

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

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 18,330	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (20,000))	517,381		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,662		6
7	Other Prepaid Expenses	1,000		7
8	Accounts Receivable (owners or related parties)	49,949		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 613,322	$	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	160,702		15
16	Equipment, at Historical Cost	65,092		16
17	Accumulated Depreciation (book methods)	(107,925)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSIT	431		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 118,300	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 731,622	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 530,322	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	760,612		29
30	Accrued Salaries Payable	29,359		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,566		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,296		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,360,155	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	127,879		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)**	$ 127,879	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,488,034	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (756,412)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 731,622	$	48

***(See instructions.)**

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (964,085)	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (964,086)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	207,674	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)**	$ 207,674	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)**	$ (756,412)	24 *

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

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,521,764	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,521,764	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	254,462	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 254,462	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***	6,496	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,496	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)**	$ 3,782,722	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	696,130	31
32	Health Care	1,245,125	32
33	General Administration	899,645	33
	B. Capital Expense		
34	Ownership	285,591	34
	C. Ancillary Expense		
35	Special Cost Centers	427,239	35
36	Provider Participation Fee	37,778	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(16,460)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,575,048	40
41	**Income before Income Taxes (line 30 minus line 40)****	207,674	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 207,674	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.**

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,889	2,150	$ 59,687	$ 27.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,966	3,243	73,401	22.63	3
4	Licensed Practical Nurses	15,163	16,513	347,001	21.01	4
5	CNAs & Orderlies	44,642	48,800	511,314	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,068	2,298	34,021	14.80	9
10	Activity Assistants	3,825	4,294	40,494	9.43	10
11	Social Service Workers	597	610	6,108	10.01	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,207	43,031	19.50	13
14	Head Cook	6,074	6,986	70,971	10.16	14
15	Cook Helpers/Assistants	9,228	10,455	88,289	8.44	15
16	Dishwashers					16
17	Maintenance Workers	2,016	2,325	39,725	17.09	17
18	Housekeepers	14,778	16,177	152,316	9.42	18
19	Laundry	348	415	3,467	8.35	19
20	Administrator	3,985	4,277	118,776	27.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,545	3,941	69,386	17.61	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	1,981	2,075	26,293	12.67	31
32	Other Health Care(specify)					32
33	Other(specify) marketing dir.	103	108	1,363	12.62	33
34	TOTAL (lines 1 - 33)	115,192	126,874	$ 1,685,643 *	$ 13.29	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 4,467	1-3	35
36	Medical Director	O	11,250	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,343	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) PSYCHIATRIC	S	17,200	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 36,260		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KIM HAAS	ADMINISTRATOR	0	$ 75,235
CRAIG FRANK	OTHER ADMIN	10	43,541
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 118,776

B. Administrative - Other

Description	Amount
ASTA HEALTHCARE MANAGEMENT, INC.	$ 145,000
CRAIG FRANK	25,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 170,000

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		59,906
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 59,906

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,996
Unemployment Compensation Insurance	24,778
FICA Taxes	118,278
Employee Health Insurance	34,713
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,205
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 271,970

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	981
Health Care Worker Background Check	450
(Indicate # of checks performed 45)	
Patient Background Checks 1050	1,050
TRUST/FRANCHISE/CONTRIB/ETC	4,400
MARKETING/ADV/PROMO	6,375
LICENSES/DUES/SUBSCRIPTIONS	4,611
MGMT CO ALLOC	624
TRUST/FRANCHISE/CONTRIB/ETC	(4,400)
Less: Public Relations Expense	(0)
Non-allowable advertising	(6,375)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,716

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
MGMT CO ALLOC	312
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 312

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

Facility Name & ID Number ASTA CARE CENTER - FORD COUNTY # 0045823 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTHCARE ASSOC $3491**

(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. $ **36,274** 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. $ **37,778**
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 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.