		FOR BHF USE			

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

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: 0041608

Facility Name: ASTA CARE CENTER OF ELGIN

Address: 134 NORTH MCLEAN BOULEVARD (Number) ELGIN (City) 60123 (Zip Code)

County: KANE

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

HFS ID Number:

Date of Initial License for Current Owners: 03/29/96

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code
- [X] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [X] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 OF ELGIN # 0041608 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	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	52	Skilled (SNF)	52	18,980	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,230	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	875	409	4,804	6,088	8
9	SNF/PED					9
10	ICF	24,116	1,979		26,095	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,991	2,388	4,804	32,183	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.44%

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 03/29/96

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 52 and days of care provided 4,804

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.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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 Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	292,809	27,093	11,881	331,783		331,783	0	331,783			1
2	Food Purchase		187,481		187,481	0	187,481	(1,538)	185,943			2
3	Housekeeping	288,427	27,897	0	316,324		316,324	0	316,324			3
4	Laundry	67,995	12,990	0	80,985	0	80,985	0	80,985			4
5	Heat and Other Utilities			100,744	100,744		100,744	0	100,744			5
6	Maintenance	57,575	37,400	30,920	125,895		125,895	0	125,895			6
7	Other (specify):*			41,431	41,431		41,431	0	41,431			7
8	TOTAL General Services	706,806	292,861	184,976	1,184,643	0	1,184,643	(1,538)	1,183,105			8
	B. Health Care and Programs											
9	Medical Director	0		9,000	9,000		9,000	0	9,000			9
10	Nursing and Medical Records	1,485,083	165,610	5,901	1,656,594	3,848	1,660,442	8,857	1,669,299			10
10a	Therapy	135,278	8,971	421	144,670		144,670	0	144,670			10a
11	Activities	105,276	23,988	6,092	135,356		135,356	0	135,356			11
12	Social Services	106,309		10,508	116,817		116,817	0	116,817			12
13	CNA Training			0	0		0	0	0			13
14	Program Transportation			616	616		616	0	616			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	1,831,946	198,569	32,538	2,063,053	3,848	2,066,901	8,857	2,075,758			16
	C. General Administration											
17	Administrative	200,805		180,000	380,805		380,805	(88,568)	292,237			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			52,624	52,624	(3,848)	48,776	(657)	48,119			19
20	Dues, Fees, Subscriptions & Promotions			29,082	29,082		29,082	(21,463)	7,619			20
21	Clerical & General Office Expenses	150,298	39,225	140,466	329,989		329,989	(75,660)	254,329			21
22	Employee Benefits & Payroll Taxes			401,852	401,852	0	401,852	0	401,852			22
23	Inservice Training & Education			2,967	2,967		2,967	0	2,967			23
24	Travel and Seminar			0	0		0	438	438			24
25	Other Admin. Staff Transportation			5,209	5,209		5,209	3,354	8,563			25
26	Insurance-Prop.Liab.Malpractice			87,455	87,455		87,455	1,334	88,789			26
27	Other (specify):*			97,288	97,288		97,288	(88,516)	8,772			27
28	TOTAL General Administration	351,103	39,225	996,943	1,387,271	(3,848)	1,383,423	(269,738)	1,113,685			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,889,855	530,655	1,214,457	4,634,967	0	4,634,967	(262,419)	4,372,548			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 OF ELGIN #0041608 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	9,126	
	REPAIRS & MAINTENANCE		1,999	
	OUTSIDE SERVICES		756	11,881
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		19,143	
	ELECTRICITY		40,934	
	WATER		37,857	
	CABLE TV - LOBBY		2,810	
			0	100,744
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,040	
	PAINTING & DECORATING		1,768	
	BUILDING REPAIRS		1,518	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		13,147	
	ELEVATOR MAINTENANCE & REPAIR		1,141	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,530	
	FIRE SERVICE		7,776	
			0	
			0	
			0	
			0	30,920
7	**OTHER**			
	SCAVENGER		40,487	
	SECURITY SERVICE		944	
			0	
			0	41,431
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,000	9,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,307	
	PHARMACY CONSULTANT	XVIII B 39-2	4,594	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	5,901
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		421	
	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	
				421
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	6,092	
			0	6,092
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		2,465	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	8,043	
			0	10,508
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CENTER OF ELGIN #0041608 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		616	616
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	180,000	180,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	23,324	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	29,300	
			0	52,624
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	18,837	
	EMPLOYEE WANT ADS	XIX F	480	
	CONTRIBUTIONS	VI 20 XIX F	1,800	
	DUES & SUBSCRIPTIONS	XIX F	1,704	
	LICENSES & PERMITS	XIX F	2,591	
	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	1,700	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	680	
	PATIENT BACKGROUND CHECKS	XIX F	1,290	
				29,082
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		7,310	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		680	
	PENALTIES / OVERDRAFT CHARGES	VI 18	93,996	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		34,985	
	MESSENGER SERVICE		3,495	
			0	140,466

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	211,224	
	UNEMPLOYMENT COMPENSATION	XIX D	49,740	
	WORKERS COMPENSATION INSURANC	XIX D	93,970	
	HOSPITALIZATION INSURANCE	XIX D	45,150	
	EMPLOYEE BENEFITS - OTHER	XIX D	315	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,453	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	401,852
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,967	
				2,967
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,209	
				5,209
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		87,455	
				87,455
27	**OTHER**			
	BAD DEBTS	VI 24	97,288	
				97,288

GRAND TOTAL COLUMN 3 OTHER **1,214,457**

ASTA CARE CENTER OF ELGIN
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	187,481
LESS SALES TAX	(1,538)
NET FOOD	185,943
TOTAL PATIENT CENSUS	32,183
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	96,549
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	96,549
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	96,549
NET FOOD	185,943
DIVIDE TOTAL MEALS/YEAR	96,549
COST PER MEAL	1.93
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number ASTA CARE CENTER OF ELGIN #0041608 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			44,399	44,399		44,399	(31,633)	12,766			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			58,038	58,038		58,038	(11,069)	46,969			32
33	Real Estate Taxes			94,872	94,872		94,872	0	94,872			33
34	Rent-Facility & Grounds			464,280	464,280		464,280	0	464,280			34
35	Rent-Equipment & Vehicles			34,318	34,318		34,318	0	34,318			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			695,907	695,907	0	695,907	(42,702)	653,205			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		257,745	604,976	862,721		862,721	0	862,721			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			55,845	55,845		55,845	0	55,845			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	257,745	660,821	918,566	0	918,566	0	918,566			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,889,855	788,400	2,571,185	6,249,440	0	6,249,440	(305,121)	5,944,319			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 OF ELGIN # 0041608 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 Reference	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	(31,633)	30		9
10	Interest and Other Investment Income	(927)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,538)	2		13
14	Non-Care Related Interest	(10,142)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(93,996)	21		18
19	Entertainment	0	20		19
20	Contributions	(3,500)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(1,696)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(97,288)	27		24
25	Fund Raising, Advertising and Promotional	(18,837)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(22,321)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (281,878)		$ 0	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)	(23,243)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (23,243)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (305,121)		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

ASTA CARE CENTER OF ELGIN

ID# 0041608

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	NON ALLOWABLE TRAVEL	(3,673)	25	2
3	MARKETING SALARY	(18,648)	21	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
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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**	(22,321)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	(1,538)	0	0	0	0	0	0	0	0	0	0	(1,538)	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**	(1,538)	0	0	0	0	0	0	0	0	0	0	(1,538)	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	8,857	0	0	0	0	0	0	0	0	0	8,857	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	8,857	0	0	0	0	0	0	0	0	0	8,857	16
	C. General Administration													
17	Administrative	0	(88,568)	0	0	0	0	0	0	0	0	0	(88,568)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,696)	1,039	0	0	0	0	0	0	0	0	0	(657)	19
20	Fees, Subscriptions & Promotions	(22,337)	874	0	0	0	0	0	0	0	0	0	(21,463)	20
21	Clerical & General Office Expenses	(112,644)	36,984	0	0	0	0	0	0	0	0	0	(75,660)	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	438	0	0	0	0	0	0	0	0	0	438	24
25	Other Admin. Staff Transportation	(3,673)	7,027	0	0	0	0	0	0	0	0	0	3,354	25
26	Insurance-Prop.Liab.Malpractice	0	1,334	0	0	0	0	0	0	0	0	0	1,334	26
27	Other (specify):*	(97,288)	8,772	0	0	0	0	0	0	0	0	0	(88,516)	27
28	**TOTAL General Administration**	(237,638)	(32,100)	0	0	0	0	0	0	0	0	0	(269,738)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(239,176)	(23,243)	0	0	0	0	0	0	0	0	0	(262,419)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(31,633)	0	0	0	0	0	0	0	0	0	0	(31,633)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,069)	0	0	0	0	0	0	0	0	0	0	(11,069)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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**	(42,702)	0	0	0	0	0	0	0	0	0	0	(42,702)	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)**	(281,878)	(23,243)	0	0	0	0	0	0	0	0	0	(305,121)	45

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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		
				HEALTHCARE CO.	ELGIN	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				ASTA THERAPY	ELGIN	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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 FEES	$ 180,000	ASTA HEALTHCARE COMPANY, INC.		$	$ (180,000)	1
2	V	10	NURSING				8,857	8,857	2
3	V	17	ADMINISTRATIVE				91,432	91,432	3
4	V	19	PROFESSIONAL FEES				1,039	1,039	4
5	V	20	LICENSES & PERMITS				874	874	5
6	V	21	OFFICE EXPENSE				36,984	36,984	6
7	V	24	SEMINARS				438	438	7
8	V	25	STAFF TRANS/ TRAVEL				7,027	7,027	8
9	V	26	INSURANCE GEN / WC				1,334	1,334	9
10	V	27	PAYR. TAXES & GRP INS				8,772	8,772	10
11	V								11
12	V								12
13	V								13
14	Total			$ 180,000			$ 156,757	$ * (23,243)	14

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	$ 34,809	17-7	1
2											2
3											3
4											4
5	CRAIG FRANK				SEE	SEE					5
6	SALARY FROM ASTA CARE OF FORD COUNTY $43,541				ATTACHED	ATTACHED		SALARY	35,590	17-7	6
7	MANAGEMENT FEE FROM ASTA CARE OF FORD COUNTY $25,000				SCHEDULE	SCHEDULE					7
8											8
9	DAVID MEISELMAN										9
10	SALARY FROM ASTA CARE OF ELGIN $166,160							SALARY	166,160	17-1	10
11											11
12	ALIZA FRANK		PAYROLL					SALARY	6,322	17-7	12
13								TOTAL	$ 242,881		13

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

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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 COMPANY
Street Address: 134 NORTH MCLEAN BLVD
City / State / Zip Code: ELGIN, IL 60123
Phone Number: (847) 742 - 8822
Fax Number: (847) 742 - 9013

	1 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	32,183	$ 8,857	1
2	17	OFFICER'S SALARY -MG	PATIENT DAYS	180,290	7	195,000	195,000	32,183	34,809	2
3	17	ADMIN. SALARY -CF	PATIENT DAYS	180,290	7	199,375	199,375	32,183	35,590	3
4	17	ADMIN. SALARY -AF	PATIENT DAYS	180,290	7	35,417	35,417	32,183	6,322	4
5	17	ADMIN. SALARY- JS	PATIENT DAYS	180,290	7	82,414	82,414	32,183	14,711	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	180,290	7	5,819		32,183	1,039	6
7	20	LICENSES & PERMITS	PATIENT DAYS	180,290	7	4,897		32,183	874	7
8	21	OFFICE EXPENSE	PATIENT DAYS	180,290	7	207,187	169,766	32,183	36,984	8
9	24	SEMINARS	PATIENT DAYS	180,290	7	2,453		32,183	438	9
10	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	180,290	7	39,363		32,183	7,027	10
11	26	INSURANCE GEN / WC	PATIENT DAYS	180,290	7	7,472		32,183	1,334	11
12	27	PAYR. TAXES & GRP INS	PATIENT DAYS	180,290	7	49,140		32,183	8,772	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		$ 156,757	25

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	ELGIN NURSING HOME-PROP.		X								2,487	5
	Working Capital											
6	FIRST CHICAGO BANK & TRUST		X	WORKING CAPITAL	INT	REVOLV		393,129			34,021	6
7	HARRIS BANK-MEMBER			WORKING CAPITAL		8/5/10	200,000			10.0000	6,729	7
8	INSURANCE POLICIES		X								4,659	8
9	TOTAL Facility Related						$ 200,000	$ 393,129			$ 47,896	9
	B. Non-Facility Related*											
10												10
11	BED TAX										4,178	11
12	MISC										5,964	12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 10,142	14
15	TOTALS (line 9+line14)						$ 200,000	$ 393,129			$ 58,038	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 OF ELGIN # 0041608 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2009 report.	$	84,942	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.)	$	89,907	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,965	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	89,907	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.	$	94,872	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		Line
2005	80,254	8
2006	84,432	9
2007	83,945	10
2008	84,942	11
2009	89,907	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 105% OF THE PRIOR YEAR REAL ESTATE TAX BILL
THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

FOR BHF USE ONLY

Line	Item		Amount	Line
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 OF ELGIN COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0041608

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)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	06-15-176-011	NURSING HOME	$ 82,131.50	$ 82,131.50
2.	06-15-176-043	NURSING HOME	$ 1,043.64	$ 1,043.64
3.	06-15-176-044	NURSING HOME	$ 6,731.94	$ 6,731.94
4.			$	$ 0.00
5.			$	$ 0.00
6.			$	$ 0.00
7.			$	$ 0.00
8.			$	$ 0.00
9.			$	$ 0.00
10.			$	$ 0.00
		TOTALS	$ 89,907.08	$ 89,907.08

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: ______ B. General Construction Type: Exterior ______ Frame ______ Number of Stories ______

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [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 [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				$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOOR DRAIN			1997	1,297	33	39	33		447	9
10	INSTALL SHOWER VALVE AND DRAIN			1997	4,142	105	39	105		1,423	10
11	RE KEY DOOR LOCKS			1997	4,085	104	39	104		1,409	11
12	NEW AIR VENTS			1997	616	18	39	18		243	12
13	FIRE ALARM SYSTEM			1997	2,192	56	39	56		758	13
14	AWNINGS			1997	1,020	26	39	26		352	14
15	SEWAGE EJECTOR PUMP			1998	3,961	102	39	102		1,287	15
16	HOT WATER PUMP			1998	5,439	139	39	139		1,697	16
17	AWNINGS			1999	685	25	27.5	25		289	17
18	FLOORING			1999	2,474	90	27.5	90		1,039	18
19	ELECTRICAL WORK			1999	9,378	341	27.5	341		3,936	19
20	MAGNETIC DOOR LOCKS			1999	2,054	74	27.5	74		854	20
21	FIRE SPRINKLER SYSTEM			1999	3,868	141	27.5	141		1,627	21
22	BOILER			1999	4,890	178	27.5	178		2,054	22
23	NURSE STATION			2000	16,280	592	27.5	592		6,241	23
24	CONDENSING UNIT			2000	4,683	170	27.5	170		1,792	24
25	WATER HEATER			2000	8,731	317	27.5	317		3,342	25
26	POWER VENT FOR WATER HEATER			2000	2,682	98	27.5	98		1,033	26
27	NEW WALLS			2000	2,000	73	27.5	73		769	27
28	HOT WATER PIPING			2000	4,708	171	27.5	171		1,803	28
29	DRAPERIES			2000	2,303		7			2,303	29
30	EJECTOR PUMP			2001	14,041	511	27.5	511		4,876	30
31	ROOF			2001	6,218	226	27.5	226		2,156	31
32	COMPRESSOR			2001	3,501	127	27.5	127		1,212	32
33	PRESSURE BACK FLOW PREVENTER			2002	3,870	141	27.5	141		1,204	33
34	FIRE ALARM SYSTEM			2002	37,625	1,368	27.5	1,368		11,685	34
35	RE KEY LOCKS			2002	1,346	49	27.5	49		419	35
36	PATIENT SECURITY SYSTEM			2002	2,719	99	27.5	99		845	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	WATER HEATER	2002	$ 4,864	$ 177	27.5	$ 177	$	$ 1,512	37
38	NEW PIPE	2002	1,575	57	27.5	57		487	38
39	VINYL FLOORING	2002	17,779		5			17,779	39
40	HANDRAILS,BUMPERS,CORNER	2003	17,903	651	27.5	651		4,910	40
41	SMOKE DAMPERS	2003	1,904	69	27.5	69		520	41
42	DOOR ALARM SYSTEM	2003	3,097	113	27.5	113		852	42
43	SMOKING PORCH	2003	764	28	27.5	28		211	43
44	WALLCOVERINGS & PAINTING	2003	26,197		5			26,197	44
45	DIALYSIS ROOM	2004	23,267	846	27.5	846		5,534	45
46	VALVE ACTUATOR	2004	3,240	118	27.5	118		713	46
47	HOT WATER HEATER	2004	6,837	248	27.5	248		1,498	47
48	CURTAINS	2005	1,513	88	5		(88)	1,513	48
49	FIRE ALARM SYSTEM	2005	4,026	146	27.5	146		809	49
50	SPRINKLER HEADS	2005	2,530	92	27.5	92		510	50
51	FIRE DOOR	2005	547	20	27.5	20		111	51
52	ASPHALT	2005	6,000	400	15	400		2,217	52
53	ELEVATOR EMERGENCY STOP SWITCH	2006	1,849	67	27.5	67		304	53
54	PARKING LOT	2007	26,200	1,747	15	1,747		6,042	54
55	BOILER	2007	4,245	154	27.5	154		533	55
56	WATER HEATER	2007	6,453	235	27.5	235		812	56
57	NURSE CALL SYSTEM	2007	2,536	92	27.5	92		318	57
58	A/C CONDENSER	2007	5,928	216	27.5	216		747	58
59	5 TON A/C	2007	3,000	109	27.5	109		377	59
60	BLACK TOP AND SEAL THE PARKING LOT	2008	10,700	713	15	713		1,515	60
61	ROOF	2008	3,800	137	27.5	137		337	61
62	GENERATOR REPAIR	2008	4,578	168	27.5	168		413	62
63	EJECTOR PUMP	2009	3,125	114	27.5	114		166	63
64	CUSTOM CABINETS IN PT ROOM	2009	8,200	298	27.5	298		434	64
65	GENERATOR PANELS	2009	4,297	156	27.5	156		228	65
66	DISTRIBUTION PANEL	2010	9,758	162	27.5	162		162	66
67	WATER MAIN	2010	3,527	59	27.5	59		59	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 377,047	$ 12,854		$ 12,766	$ (88)	$ 134,915	70

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	$ 305,045	$ 8,803	$	$ (8,803)		$ 214,410	71
72	Current Year Purchases	29,483	22,742		(22,742)			72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 334,528	$ 31,545	$ 0	$ (31,545)		$ 214,410	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				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	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)	$ 711,575	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 44,399	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 12,766	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (31,633)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 349,325	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 OF ELGIN # 0041608 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: ELGIN NURSING HOME PROPERTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [x] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		102		$ 464,280			3
4	Additions							4
5								5
6								6
7	TOTAL		102		$ 464,280 **			7

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2011	$ 464,280
13.	/2012	$ 464,280
14.	/2013	$ 464,280

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 30,593 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	ADMINISTRATOR	2010 LICOLN MKX	$ 727.03	$ 3,725	17
18					18
19					19
20					20
21	TOTAL		$ 727.03	$ 3,725	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 OF ELGIN # 0041608 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	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

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 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	$		$ 129,342	$		$ 129,342	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			43,850			43,850	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			338,579			338,579	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				239,078		239,078	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): I.V. THERAPY	39-3				93,205			93,205	12
13	Medical Supplies, Radiology,Laboratory, Other (specify): Other services	39-2					18,667		18,667	13
14	TOTAL			$		$ 604,976	$ 257,745		$ 862,721	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.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	$ 20,335	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 20,000)	875,037		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,215		6
7	Other Prepaid Expenses	3,570		7
8	Accounts Receivable (owners or related parties)	598,006		8
9	Other(specify): Real Estate Escrow Deposit	5,166		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,544,329	$ 0	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	377,047		15
16	Equipment, at Historical Cost	334,528		16
17	Accumulated Depreciation (book methods)	(453,214)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Security Deposit	16,895		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 275,256	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,819,585	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,317,580	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	435,683		29
30	Accrued Salaries Payable	137,989		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,274		31
32	Accrued Real Estate Taxes(Sch.IX-B)	89,907		32
33	Accrued Interest Payable	6,729		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,010,162	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	867,404		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)**	$ 867,404	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,877,566	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,057,981)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,819,585	$ 0	48

*(See instructions.)

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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**	$ (1,184,886)	1
2	Restatements (describe):		2
3	Rounding	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,184,882)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	126,901	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)**	$ 126,901	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,057,981)	24 *

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	$ 5,962,233	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,962,233	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	297,708	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 297,708	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	116,238	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)**	$ 116,238	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	927	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 927	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)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,377,106	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,184,643	31
32	Health Care	2,063,053	32
33	General Administration	1,387,271	33
	B. Capital Expense		
34	Ownership	695,907	34
	C. Ancillary Expense		
35	Special Cost Centers	862,721	35
36	Provider Participation Fee	55,845	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	765	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,250,205	40
41	**Income before Income Taxes (line 30 minus line 40)****	126,901	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 126,901	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 OF ELGIN # 0041608 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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,061	2,263	$ 97,444	$ 43.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,611	10,634	261,763	24.62	3
4	Licensed Practical Nurses	14,448	13,658	456,780	33.44	4
5	CNAs & Orderlies	54,691	56,202	626,180	11.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,992	5,461	135,278	24.77	8
9	Activity Director	1,994	2,267	42,680	18.83	9
10	Activity Assistants	5,764	6,323	62,596	9.90	10
11	Social Service Workers	3,786	4,114	106,309	25.84	11
12	Dietician					12
13	Food Service Supervisor	2,022	2,312	58,210	25.18	13
14	Head Cook	12,448	14,230	194,663	13.68	14
15	Cook Helpers/Assistants	3,697	3,925	39,936	10.17	15
16	Dishwashers					16
17	Maintenance Workers	2,046	2,338	57,575	24.63	17
18	Housekeepers	22,902	25,412	288,427	11.35	18
19	Laundry	6,311	6,953	67,995	9.78	19
20	Administrator	2,086	2,086	200,805	96.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,774	7,318	150,298	20.54	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	1,982	2,102	42,916	20.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,615	167,598	$ 2,889,855 *	$ 17.24	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	$ 9,126	1-3	35
36	Medical Director	O	9,000	9-3	36
37	Medical Records Consultant	N	1,307	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,594	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	6,092	11-3	44
45	Social Service Consultant	E	8,043	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 38,162		49

C. CONTRACT NURSES

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DAVID MEISELMAN	ADMINISTRATOR	0	$ 166,160
JACOB SIEGEL	ASST ADMIN	0	34,645
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 200,805

B. Administrative - Other

Description	Amount
ASTA HEALTHCARE MANAGEMENT, INC	$ 180,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 180,000

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		52,624
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 52,624

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 93,970
Unemployment Compensation Insurance		49,740
FICA Taxes		211,224
Employee Health Insurance		45,150
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		315
EMPLOYEE PHYSICAL EXAMS		1,453
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)		$ 401,852

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		480
Health Care Worker Background Check		680
(Indicate # of checks performed	68)	
Patient Background Checks	129	1,290
TRUST/FRANCHISE/CONTRIB/ETC		3,500
MARKETING/ADV/PROMO		18,837
LICENSES/DUES/SUBSCRIPTIONS		4,295
MGMT CO ALLOC		874
TRUST/FRANCHISE/CONTRIB/ETC		(3,500)
Less: Public Relations Expense		(0)
Non-allowable advertising		(18,837)
Yellow page advertising		(0)
TOTAL (agree to Sch. V, line 20, col. 8)		$ 7,619

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
MGMT CO ALLOC	438
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 438

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8							N/A						
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. **IL HEALTHCARE ASSOCIATES $3,379**

(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. $ **32,302** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. ______

(9) Are you presently operating under a sublease agreement? ______ YES ______ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ______ NO ______ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

______

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **55,845**
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.