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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0045823

Facility Name: ASTA CARE CENTER-FORD COUNTY

Address: 1240 NORTH MARKET ST (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: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2013 to 12/31/2013 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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: 01/01/2013 Ending: 12/31/2013

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 02/26/2013

	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)	76	27,348	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	76	27,348	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	30	27	2,272	2,329	8
9	SNF/PED					9
10	ICF	15,347	2,406	437	18,190	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,377	2,433	2,709	20,519	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.03%

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 58 and days of care provided 2,184

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	177,991	16,389	18,743	213,123		213,123		213,123			1
2	Food Purchase		132,510		132,510		132,510	(1,365)	131,145			2
3	Housekeeping	176,641	39,279		215,920		215,920		215,920			3
4	Laundry	5,092	8,950		14,042		14,042		14,042			4
5	Heat and Other Utilities			82,045	82,045		82,045		82,045			5
6	Maintenance	38,098	13,693	29,566	81,357		81,357		81,357			6
7	Other (specify):*			12,895	12,895		12,895		12,895			7
8	**TOTAL General Services**	397,822	210,821	143,249	751,892		751,892	(1,365)	750,527			8
	B. Health Care and Programs											
9	Medical Director			11,750	11,750		11,750		11,750			9
10	Nursing and Medical Records	1,129,348	104,513	7,380	1,241,241		1,241,241	3,046	1,244,287			10
10a	Therapy		1,843		1,843		1,843		1,843			10a
11	Activities	66,084	2,988		69,072		69,072		69,072			11
12	Social Services	32,050			32,050		32,050		32,050			12
13	CNA Training											13
14	Program Transportation			2,800	2,800		2,800		2,800			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,227,482	109,344	21,930	1,358,756		1,358,756	3,046	1,361,802			16
	C. General Administration											
17	Administrative	72,430		210,975	283,405		283,405	(70,415)	212,990			17
18	Directors Fees											18
19	Professional Services			87,003	87,003		87,003	4,505	91,508			19
20	Dues, Fees, Subscriptions & Promotions			18,690	18,690		18,690	(6,541)	12,149			20
21	Clerical & General Office Expenses	67,077	25,481	30,515	123,073		123,073	(5,185)	117,888			21
22	Employee Benefits & Payroll Taxes			309,163	309,163		309,163		309,163			22
23	Inservice Training & Education			1,455	1,455		1,455		1,455			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			14,755	14,755		14,755	3,191	17,946			25
26	Insurance-Prop.Liab.Malpractice			53,526	53,526		53,526		53,526			26
27	Other (specify):*			52,650	52,650		52,650	(48,611)	4,039			27
28	**TOTAL General Administration**	139,507	25,481	778,732	943,720		943,720	(123,056)	820,664			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,764,811	345,646	943,911	3,054,368		3,054,368	(121,375)	2,932,993			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: 01/01/2013** **Ending: 12/31/2013**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,439	
	REPAIRS & MAINTENANCE		12,304	
			0	18,743
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		19,382	
	ELECTRICITY		36,554	
	WATER		24,243	
	CABLE TV - LOBBY		1,866	
			0	82,045
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,155	
	PAINTING & DECORATING		253	
	BUILDING REPAIRS		5,210	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		14,082	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,815	
	FIRE SERVICE		4,051	
			0	
			0	
			0	
			0	29,566
7	**OTHER**			
	SCAVENGER		12,895	
	SECURITY SERVICE		0	
			0	
			0	12,895
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	11,750	11,750

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		480	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,560	
	PHARMACY CONSULTANT	XVIII B 39-2	5,340	
	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	7,380
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY 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		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	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:** 01/01/2013 **Ending:** 12/31/2013

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		2,800	2,800
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	210,975	210,975
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	25,560	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	61,443	
			0	87,003
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	6,367	
	EMPLOYEE WANT ADS	XIX F	7,174	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	967	
	LICENSES & PERMITS	XIX F	3,020	
	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	500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	300	
	PATIENT BACKGROUND CHECKS	XIX F	362	
				18,690
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		12,978	
	EQUIPMENT REPAIR & MAINTENANCE		252	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	4,475	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		12,810	
	MESSENGER SERVICE		0	
			0	30,515

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	131,258	
	UNEMPLOYMENT COMPENSATION	XIX D	62,555	
	WORKERS COMPENSATION INSURANC	XIX D	90,174	
	HOSPITALIZATION INSURANCE	XIX D	24,090	
	EMPLOYEE BENEFITS - OTHER	XIX D	487	
	EMPLOYEE PHYSICAL EXAMS	XIX D	599	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	309,163
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,455	
				1,455
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		14,755	
				14,755
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		53,526	
				53,526
27	**OTHER**			
	BAD DEBTS	VI 24	52,650	
				52,650

GRAND TOTAL COLUMN 3 OTHER **943,911**

ASTA CARE CENTER-FORD COUNTY
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	132,510
LESS SALES TAX	(1,365)
NET FOOD	131,145
TOTAL PATIENT CENSUS	20,519
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	61,557
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	0
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	0
NET FOOD	131,145
DIVIDE TOTAL MEALS/YEAR	0
COST PER MEAL	0.00
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY #0045823 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			116,774	116,774		116,774	(29,206)	87,568			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			98,780	98,780		98,780	128,125	226,905			32
33	Real Estate Taxes			26,316	26,316		26,316		26,316			33
34	Rent-Facility & Grounds			255,000	255,000		255,000	(255,000)				34
35	Rent-Equipment & Vehicles			13,803	13,803		13,803		13,803			35
36	Other (specify):* Amortization			11,168	11,168		11,168		11,168			36
37	TOTAL Ownership			521,841	521,841		521,841	(156,081)	365,760			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,320	276,910	370,230		370,230	(31,013)	339,217			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			156,486	156,486		156,486		156,486			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		93,320	433,396	526,716		526,716	(31,013)	495,703			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,764,811	438,966	1,899,148	4,102,925		4,102,925	(308,469)	3,794,456			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: 01/01/2013 Ending: 12/31/2013

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	(90,714)	30		9
10	Interest and Other Investment Income	(1,952)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,365)	2		13
14	Non-Care Related Interest	(29,646)	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	(4,475)	21		18
19	Entertainment		20		19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,650)	27		24
25	Fund Raising, Advertising and Promotional	(6,367)	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	(56,372)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (244,041)		$	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)	(64,428)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (64,428)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (308,469)		37

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

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

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

ASTA CARE CENTER-FORD COUNTY

ID# 0045823

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (24,275)	21	1
2	STAFF TRANSPORTATION - MARKETING	(1,084)	25	2
3	RELATED PARTY THERAPY ADJUSTMENT	(31,013)	39	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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**	(56,372)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	(1,365)	0	0	0	0	0	0	0	0	0	0	(1,365)	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**	(1,365)	0	0	0	0	0	0	0	0	0	0	(1,365)	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	3,046	0	0	0	0	0	0	0	0	0	3,046	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	3,046	0	0	0	0	0	0	0	0	0	3,046	16
	C. General Administration													
17	Administrative	0	(70,415)	0	0	0	0	0	0	0	0	0	(70,415)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,505	0	0	0	0	0	0	0	0	0	4,505	19
20	Fees, Subscriptions & Promotions	(6,867)	326	0	0	0	0	0	0	0	0	0	(6,541)	20
21	Clerical & General Office Expenses	(28,750)	23,565	0	0	0	0	0	0	0	0	0	(5,185)	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	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,084)	4,275	0	0	0	0	0	0	0	0	0	3,191	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(52,650)	4,039	0	0	0	0	0	0	0	0	0	(48,611)	27
28	**TOTAL General Administration**	(89,351)	(33,705)	0	0	0	0	0	0	0	0	0	(123,056)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(90,716)	(30,659)	0	0	0	0	0	0	0	0	0	(121,375)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	(90,714)	0	61,508	0	0	0	0	0	0	0	0	(29,206)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31,598)	0	159,723	0	0	0	0	0	0	0	0	128,125	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(255,000)	0	0	0	0	0	0	0	0	(255,000)	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**	(122,312)	0	(33,769)	0	0	0	0	0	0	0	0	(156,081)	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	(31,013)	0	0	0	0	0	0	0	0	0	0	(31,013)	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**	(31,013)	0	0	0	0	0	0	0	0	0	0	(31,013)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(244,041)	(30,659)	(33,769)	0	0	0	0	0	0	0	0	(308,469)	45

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MICHAEL GILLMAN	60	ASTA CARE CENTER OF BLOOMINGTON	BLOOMINGTON	ASTA		
DARRYLE GILLMAN	10	ASTA CARE CENTER OF COLFAX	COLFAX	HEALTHCARE CO.	ELGIN	MANAGEMENT
SETH GILLMAN	10	ASTACARE CENTER OF ELGIN	ELGIN			
DAVID MEISELMAN	10	ASTA CARE CENTER OF PONTIAC	PONTIAC			
CRAIG FRANK	10	ASTA CARE CENTER OF ROCKFORD	ROCKFORD	ASTA THERAPY		THERAPY
		ASTA CARE CENTER OF TOLUCA	TOLUCA	ASTA PAXTON		REAL ESTATE
				PROPERTIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 113,475	ASTA HEALTHCARE COMPANY, INC.		$	$ (113,475)	1
2	V	10	NURSING		ASTA HEALTHCARE COMPANY, INC.		3,046	3,046	2
3	V	17	OFFICER'S SALARY -MG		ASTA HEALTHCARE COMPANY, INC.		21,450	21,450	3
4	V	17	ADMIN. SALARY -CF		ASTA HEALTHCARE COMPANY, INC.		17,964	17,964	4
5	V	17	ADMIN. SALARY -AF		ASTA HEALTHCARE COMPANY, INC.		3,646	3,646	5
6	V	19	PROFESSIONAL FEES		ASTA HEALTHCARE COMPANY, INC.		4,505	4,505	6
7	V	20	LICENSES & PERMITS		ASTA HEALTHCARE COMPANY, INC.		326	326	7
8	V	21	OFFICE EXPENSE		ASTA HEALTHCARE COMPANY, INC.		23,565	23,565	8
9	V	25	STAFF TRANS/ TRAVEL		ASTA HEALTHCARE COMPANY, INC.		4,275	4,275	9
10	V	27	PAYR. TAXES & W/C		ASTA HEALTHCARE COMPANY, INC.		4,039	4,039	10
11	V								11
12	V								12
13	V								13
14	Total			$ 113,475			$ 82,816	$ * (30,659)	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: 01/01/2013 Ending: 12/31/2013

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	$ 255,000	ASTA PAXTON PROPERTIES		$	$ (255,000)	15
16	V	30	DEPRECIATION				61,508	61,508	16
17	V	32	AMORT LOAN COSTS				7,289	7,289	17
18	V	32	INTEREST				152,434	152,434	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			$ 255,000			$ 221,231	$ * (33,769)	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: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	PRESIDENT	administrative/	60.00				SALARY	$ 21,450	17-7	1
2			management								2
3	CRAIG FRANK	CFO	finance manage.	10.00	SEE	SEE		SALARY	17,964	17-7	3
4					ATTACHED	ATTACHED		MGMNT			4
5					SCHEDULE	SCHEDULE		FEE	97,500	17-3	5
6	MANAGEMENT FEE FROM ASTA CARE OF COLFAX $30,000				SCHEDULE						6
7											7
8	ALIZA FRANK	PAYROLL CLERK	PAYROLL					SALARY	3,646	17-7	8
9											9
10	DAVID MEISELMAN	THERAPY MGMNT	management	10.00				SALARY	23,036	39-3	10
11											11
12											12
13								TOTAL	$ 163,596		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: 01/01/2013 Ending: 2/31/2013

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	191,321	7	$ 28,405	$ 28,303	20,519	$ 3,046	1
2	17	OFFICER'S SALARY -MG	PATIENT DAYS	191,321	7	200,000	200,000	20,519	21,450	2
3	17	ADMIN. SALARY -CF	PATIENT DAYS	191,321	7	167,500	167,500	20,519	17,964	3
4	17	ADMIN. SALARY -AF	PATIENT DAYS	191,321	7	34,000	34,000	20,519	3,646	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	191,321	7	42,001		20,519	4,505	5
6	20	LICENSES & PERMITS	PATIENT DAYS	191,321	7	3,043		20,519	326	6
7	21	OFFICE EXPENSE	PATIENT DAYS	191,321	7	219,718	184,734	20,519	23,565	7
8	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	191,321	7	39,861		20,519	4,275	8
9	27	PAYR. TAXES & W/C	PATIENT DAYS	191,321	7	37,656		20,519	4,039	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					$ 772,184	$ 614,537		$ 82,816	25

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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				786,666			93,594	2
3	COLE TAYLOR BANK		X	CONSTRUCTION LOAN				848,478			58,840	3
4	LOAN COSTS		X	LOAN COSTS		07/23/08	30,092				3,512	4
5	LOAN COSTS		X	LOAN COSTS		06/28/13	37,766	33,989			3,777	5
	Working Capital											
6												6
7	INSURANCE POLICIES			INS POLICY FINANCE							2,526	7
8	MIDCAP FINANCIAL			L.O.C.							48,173	8
9	TOTAL Facility Related						$ 67,858	$ 1,669,133			$ 210,422	9
	B. Non-Facility Related*											
10	Asta Care- Pontiac										10,228	10
11	Healthcare Family Services			BED TAX							19,145	11
12	ILL DEPT OF REV										69	12
13	FORD COUNTY TREASURER										204	13
14	TOTAL Non-Facility Related						$	$			$ 29,646	14
15	TOTALS (line 9+line14)						$ 67,858	$ 1,669,133			$ 240,068	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: 01/01/2013 Ending: 12/31/2013

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							$	$			$	1
2												2
3	ENLOE			TRADE PAYABLE FINANCE	$6,372.00	7/31/12	318,974	318,974	6/30/17	0.0550	16,036	3
4												4
5												5
	Working Capital											
6												6
7	MEMBER LOAN			WORKING CAPITAL							1,696	7
8	CATERPILLAR			GENERATOR PURCHASE	$438.00		22,859	7,947		0.0565	703	8
9	TOTAL Facility Related				$6,810.00		$ 341,833	$ 326,921			$ 18,435	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 341,833	$ 326,921			$ 18,435	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: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 28,157	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 27,237	2
3. Under or (over) accrual (line 2 minus line 1).		$ (921)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 27,237	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.		$ 26,316	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	32,210	8
	2009	32,296	9
	2010	27,886	10
	2011	28,157	11
	2012	27,237	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 2012 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 SANFORD BOKOR

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-14-05-300-007	NURSING HOME	$ 27,236.68	$ 27,236.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 27,236.68	$ 27,236.68

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 196,942	4
5	7		2013	2013	1,010,778	14,038	39	14,038		14,038	5
6			2013	2013	88,978	50,846	10	4,449	(46,397)	4,449	6
7											7
8											8
	Improvement Type**										
9	NURSE STATION			2002	10,000	364	27.5	364		4,140	9
10	ROOF			2002	28,434	1,034	27.5	1,034		11,762	10
11	NURSE STATION			2002	10,000	363	27.5	363		4,129	11
12	ROOF			2004	31,800	1,156	27.5	1,156		11,512	12
13	ELECTRICAL WORK			2005	3,959	144	27.5	144		1,230	13
14	SECURITY SYSTEM			2005	35,650	1,296	27.5	1,296		12,977	14
15	ASPHALT SIDEWALK			2005	2,200	147	15	147		1,231	15
16	10 TON PKG UNIT			2006	8,500	309	27.5	309		2,253	16
17	EMERGENCY SWITCH PANEL			2006	1,828	66	27.5	66		481	17
18	TILING			2006	1,091	40	27.5	40		292	18
19	WATER HEATER			2007	8,943	325	27.5	325		2,180	19
20	WATER MAIN WORK			2007	6,857	457	15	457		2,799	20
21	FLOORING			2007	11,440		5	659	659	11,440	21
22	DRAIN REPAIR (REL PARTY)			2008	8,612	313	27.5	313		1,735	22
23	FLOORING (REL PARTY)			2008	2,539	92	27.5	92		487	23
24	GENERATOR (REL PARTY)			2008	6,569	239	27.5	239		1,225	24
25	ELECTRICAL WORK (REL PARTY)			2009	4,395	160	27.5	160		740	25
26	WATER HEATER (REL PARTY)			2009	10,765	391	27.5	391		1,808	26
27	GENERATOR (REL PARTY)			2010	29,504	1,072	27.5	1,072		4,245	27
28	TILING (REL PARTY)			2010	3,426	125	27.5	125		493	28
29	CONCRETE RAMP(REL PARTY)			2010	3,000	200	15	200		700	29
30	ROOFTOP PACKAGE A/C WITH GAS HEAT (REL PARTY)			2011	8,135	296	27.5	296		728	30
31	WATER HEATER (REL PARTY)			2012	9,000	327	27.5	327		586	31
32	FIRE PROTECTION BACKFLOW (REL PARTY)			2013	4,800	67	39	67		67	32
33	ROOF TOP AC UNIT CONDENSOR (REL PARTY)			2013	2,500	35	39	35		35	33
34	KITCHEN HOOD SYSTEM			2013	6,604	77	39	77		77	34
35	3 INCH RPZ ON MAIN WATER (REL PARTY)			2013	4,884	47	39	47		47	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: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)		$ 2,357,406	$ 110,107		$ 64,369	$ (45,738)	$ 294,828	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: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 41,824	$ 493	$ 4,183	$ 3,690	10 YRS	$ 29,176	71
72	Current Year Purchases	104,306	59,734	5,216	(54,518)	10 YRS	5,216	72
73	Fully Depreciated Assets	6,980					6,980	73
74	REL PARTY	138,000	7,948	13,800	5,852		75,900	74
75	TOTALS	$ 291,110	$ 68,175	$ 23,199	$ (44,976)		$ 117,272	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2001 FORD VAN	2005	$ 16,288	$	$	$		$ 16,288	76
77										77
78										78
79										79
80	TOTALS			$ 16,288	$	$	$		$ 16,288	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)	$ 2,789,804	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 178,282	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 87,568	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (90,714)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 428,388	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: 01/01/2013 Ending: 12/31/2013

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:				$ 255,000			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 255,000 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 13,803 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: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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	$		$ 35,588	$		$ 35,588	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,395			3,395	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			225,432			225,432	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				92,948		92,948	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Radiology,Lab,I.V.Therapy,Other svc. Other (specify): Med supplies					12,495	372		12,867	13
14	TOTAL			$		$ 276,910	$ 93,320		$ 370,230	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-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2013 (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	$ 2,453	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (86,000))	1,537,978		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,375		6
7	Other Prepaid Expenses	7,500		7
8	Accounts Receivable (owners or related parties)	53,207		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,636,513	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	149,262		15
16	Equipment, at Historical Cost	269,816		16
17	Accumulated Depreciation (book methods)	(241,786)		17
18	Deferred Charges	21,405		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 Deposits	431		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 199,128	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,835,641	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 543,921	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	783,473		29
30	Accrued Salaries Payable	51,186		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,398		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,237		32
33	Accrued Interest Payable	10,228		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTERCOMPANY	989,873		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,413,316	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	261,562		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	MEMBER LOAN	110,856		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 372,418	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,785,734	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (950,093)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,835,641	$	48

***(See instructions.)**

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (454,056)	1	
2	Restatements (describe):		2	
3	ROUNDING	2	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (454,054)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(496,039)	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)**	$ (496,039)	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)**	$ (950,093)	24	*

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

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,490,847	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,490,847	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	84,183	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 84,183	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,952	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,952	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OUT-OF-PERIOD EXPENSES	5,276	28
28a	PENALTY ABATEMENT	24,628	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 29,904	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,606,886	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	751,892	31
32	Health Care	1,358,756	32
33	General Administration	943,720	33
	B. Capital Expense		
34	Ownership	521,841	34
	C. Ancillary Expense		
35	Special Cost Centers	370,230	35
36	Provider Participation Fee	156,486	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,102,925	40
41	**Income before Income Taxes (line 30 minus line 40)****	(496,039)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (496,039)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,081,806	44
45	Private Pay - Net Inpatient Revenue	411,538	45
46	Medicare - Net Inpatient Revenue	892,162	46
47	Other-(specify) INSURANCE	105,341	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,490,847	49

****TAX RETURN PREPARED ON CASH BASIS**

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

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

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

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

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	1,288	1,368	$ 37,627	$ 27.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,440	3,717	90,350	24.31	3
4	Licensed Practical Nurses	16,992	17,992	412,823	22.94	4
5	CNAs & Orderlies	48,376	51,526	555,455	10.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,068	2,298	36,195	15.75	9
10	Activity Assistants	2,552	2,912	29,889	10.26	10
11	Social Service Workers	1,990	2,120	32,050	15.12	11
12	Dietician					12
13	Food Service Supervisor	171	171	2,907	17.00	13
14	Head Cook	5,229	6,041	73,010	12.09	14
15	Cook Helpers/Assistants	9,875	11,042	102,074	9.24	15
16	Dishwashers					16
17	Maintenance Workers	1,755	2,064	38,098	18.46	17
18	Housekeepers	15,225	16,624	176,641	10.63	18
19	Laundry	429	501	5,092	10.16	19
20	Administrator	1,857	2,017	72,430	35.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,545	3,941	67,077	17.02	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	2,199	2,293	33,093	14.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	116,991	126,627	$ 1,764,811 *	$ 13.94	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	$ 6,439	1-3	35
36	Medical Director	O	11,750	9-3	36
37	Medical Records Consultant	N	1,560	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,340	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)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,089		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: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DEWAYNE TREMAIN	ADMINISTRATOR		$ 47,205
NORM GROSS	ADMINISTRATOR		25,225
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 72,430

B. Administrative - Other

Description	Amount
ASTA HEALTHCARE MANAGEMENT INC	$ 113,475
CRAIG FRANK	97,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 210,975

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		87,003
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 87,003

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,174
Unemployment Compensation Insurance	62,555
FICA Taxes	131,258
Employee Health Insurance	24,090
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	487
EMPLOYEE PHYSICAL EXAMS	599
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)	$ 309,163

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	7,174
Health Care Worker Background Check	300
(Indicate # of checks performed 30)	
Patient Background Checks 36	362
TRUST/FRANCHISE/CONTRIB/ETC	500
MARKETING/ADV/PROMO	6,367
LICENSES/DUES/SUBSCRIPTIONS	3,987
MGMT CO ALLOC	326
TRUST/FRANCHISE/CONTRIB/ETC	(500)
Less: Public Relations Expense	(0)
Non-allowable advertising	(6,367)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,149

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

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

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. 1,016**

(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. $ **22,017** 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. $ **156,486**
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.