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: 0041608

Facility Name: ASTA CARE CENTER OF ELGIN

Address: 134 N MCLEAN BLVD (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	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 OF ELGIN # 0041608 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 _____

	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	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 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,496	228	4,655	6,379	8
9	SNF/PED					9
10	ICF	22,785	887	56	23,728	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,281	1,115	4,711	30,107	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.87%

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 4,512

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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 OF ELGIN # 0041608 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				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	298,782	22,271	8,927	329,980		329,980		329,980			1
2	Food Purchase		205,766		205,766		205,766	(2,091)	203,675			2
3	Housekeeping	273,971	23,205		297,176		297,176		297,176			3
4	Laundry	73,543	14,819		88,362		88,362		88,362			4
5	Heat and Other Utilities			112,876	112,876		112,876		112,876			5
6	Maintenance	57,082	33,608	15,112	105,802		105,802		105,802			6
7	Other (specify):*			44,042	44,042		44,042		44,042			7
8	**TOTAL General Services**	703,378	299,669	180,957	1,184,004		1,184,004	(2,091)	1,181,913			8
	B. Health Care and Programs											
9	Medical Director			7,500	7,500		7,500		7,500			9
10	Nursing and Medical Records	1,527,732	174,204	11,262	1,713,198		1,713,198	4,470	1,717,668			10
10a	Therapy	133,051			133,051		133,051		133,051			10a
11	Activities	147,646	10,103	1,390	159,139		159,139		159,139			11
12	Social Services	102,559		3,551	106,110		106,110		106,110			12
13	CNA Training											13
14	Program Transportation			816	816		816		816			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,910,988	184,307	24,519	2,119,814		2,119,814	4,470	2,124,284			16
	C. General Administration											
17	Administrative	99,891		180,000	279,891		279,891	(116,819)	163,072			17
18	Directors Fees											18
19	Professional Services			102,678	102,678		102,678	6,609	109,287			19
20	Dues, Fees, Subscriptions & Promotions			17,240	17,240		17,240	(7,030)	10,210			20
21	Clerical & General Office Expenses	130,973	45,930	53,298	230,201		230,201	24,960	255,161			21
22	Employee Benefits & Payroll Taxes			445,044	445,044		445,044		445,044			22
23	Inservice Training & Education			1,384	1,384		1,384		1,384			23
24	Travel and Seminar			3,224	3,224		3,224		3,224			24
25	Other Admin. Staff Transportation			28,564	28,564		28,564	(3,295)	25,269			25
26	Insurance-Prop.Liab.Malpractice			49,085	49,085		49,085		49,085			26
27	Other (specify):*			56,692	56,692		56,692	(50,766)	5,926			27
28	**TOTAL General Administration**	230,864	45,930	937,209	1,214,003		1,214,003	(146,341)	1,067,662			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,845,230	529,906	1,142,685	4,517,821		4,517,821	(143,962)	4,373,859			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: 01/01/2013** **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	8,927	
	REPAIRS & MAINTENANCE		0	
			0	8,927
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,323	
	ELECTRICITY		37,350	
	WATER		36,000	
	CABLE TV - LOBBY		14,203	
			0	112,876
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		1,879	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,375	
	FIRE SERVICE		9,858	
			0	
			0	
			0	
			0	15,112
7	**OTHER**			
	SCAVENGER		44,042	
	SECURITY SERVICE		0	
			0	
			0	44,042
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,500	7,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,630	
	PHARMACY CONSULTANT	XVIII B 39-2	7,632	
	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	11,262
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	1,390	
			0	1,390
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,381	
	SOCIAL WORKER	XVIII B 45-2	1,170	
				3,551
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CENTER OF ELGIN #0041608 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		816	816
			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	62,213	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	40,465	
			0	102,678
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	6,909	
	EMPLOYEE WANT ADS	XIX F	2,919	
	CONTRIBUTIONS	VI 20 XIX F	100	
	DUES & SUBSCRIPTIONS	XIX F	2,313	
	LICENSES & PERMITS	XIX F	2,655	
	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	750	
	PATIENT BACKGROUND CHECKS	XIX F	1,094	
				17,240
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		13,325	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		1,308	
	PENALTIES / OVERDRAFT CHARGES	VI 18	5,396	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		31,963	
	MESSENGER SERVICE		1,306	
			0	53,298

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	215,425	
	UNEMPLOYMENT COMPENSATION	XIX D	60,986	
	WORKERS COMPENSATION INSURANC	XIX D	130,012	
	HOSPITALIZATION INSURANCE	XIX D	33,017	
	EMPLOYEE BENEFITS - OTHER	XIX D	5,153	
	EMPLOYEE PHYSICAL EXAMS	XIX D	451	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	445,044
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,384	
				1,384
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	3,224	
				3,224
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		28,564	
				28,564
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		49,085	
				49,085
27	**OTHER**			
	BAD DEBTS	VI 24	56,692	
				56,692

GRAND TOTAL COLUMN 3 OTHER **1,142,685**

ASTA CARE CENTER OF ELGIN
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	205,766
LESS SALES TAX	(2,091)
NET FOOD	203,675
TOTAL PATIENT CENSUS	30,107
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	90,321
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	90,321
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	90,321
NET FOOD	203,675
DIVIDE TOTAL MEALS/YEAR	90,321
COST PER MEAL	2.26
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN #0041608 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			22,075	22,075		22,075	13,154	35,229			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			148,786	148,786		148,786	(2,357)	146,429			32
33	Real Estate Taxes			44,848	44,848		44,848		44,848			33
34	Rent-Facility & Grounds			464,280	464,280		464,280		464,280			34
35	Rent-Equipment & Vehicles			26,286	26,286		26,286		26,286			35
36	Other (specify):* Amortization			16,510	16,510		16,510		16,510			36
37	TOTAL Ownership			722,785	722,785		722,785	10,797	733,582			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		228,730	630,000	858,730		858,730	(132,415)	726,315			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			214,825	214,825		214,825		214,825			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		228,730	844,825	1,073,555		1,073,555	(132,415)	941,140			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,845,230	758,636	2,710,295	6,314,161		6,314,161	(265,580)	6,048,581			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: 01/01/2013 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	13,154	30		9
10	Interest and Other Investment Income	(2,357)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,091)	2		13
14	Non-Care Related Interest		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	(5,396)	21		18
19	Entertainment		20		19
20	Contributions	(600)	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	(56,692)	27		24
25	Fund Raising, Advertising and Promotional	(6,909)	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	(146,203)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (207,094)		$	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)	(58,486)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (58,486)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (265,580)		37

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

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

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

STATE OF ILLINOIS **Page 5A**

ASTA CARE CENTER OF ELGIN

ID# **0041608**

Report Period Beginning: **01/01/2013**

Ending: **12/31/2013**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (4,220)	21	1
2	STAFF TRANSPORTATION - MARKETING	(9,568)	25	2
3	PROFESSIONAL FEES		19	3
4	RELATED PARTY THERAPY ADJUSTMENT	(132,415)	39	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**	(146,203)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF ELGIN **#** 0041608 **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	(2,091)	0	0	0	0	0	0	0	0	0	0	(2,091)	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**	(2,091)	0	0	0	0	0	0	0	0	0	0	(2,091)	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	4,470	0	0	0	0	0	0	0	0	0	4,470	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	4,470	0	0	0	0	0	0	0	0	0	4,470	16
	C. General Administration													
17	Administrative	0	(116,819)	0	0	0	0	0	0	0	0	0	(116,819)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,609	0	0	0	0	0	0	0	0	0	6,609	19
20	Fees, Subscriptions & Promotions	(7,509)	479	0	0	0	0	0	0	0	0	0	(7,030)	20
21	Clerical & General Office Expenses	(9,616)	34,576	0	0	0	0	0	0	0	0	0	24,960	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	(9,568)	6,273	0	0	0	0	0	0	0	0	0	(3,295)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(56,692)	5,926	0	0	0	0	0	0	0	0	0	(50,766)	27
28	**TOTAL General Administration**	(83,385)	(62,956)	0	0	0	0	0	0	0	0	0	(146,341)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(85,476)	(58,486)	0	0	0	0	0	0	0	0	0	(143,962)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 **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	13,154	0	0	0	0	0	0	0	0	0	0	13,154	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,357)	0	0	0	0	0	0	0	0	0	0	(2,357)	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**	10,797	0	0	0	0	0	0	0	0	0	0	10,797	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	(132,415)	0	0	0	0	0	0	0	0	0	0	(132,415)	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**	(132,415)	0	0	0	0	0	0	0	0	0	0	(132,415)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(207,094)	(58,486)	0	0	0	0	0	0	0	0	0	(265,580)	45

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	40	ASTA CARE CENTER OF BLOOMINGTON	BLOOMINGTON	ASTA		
DARRYLE GILLMAN	40	ASTA CARE CENTER OF COLFAX	COLFAX	HEALTHCARE CO.	ELGIN	MANAGEMENT
ARIEL GLAUBACH	7.5	ASTA CARE CENTER OF FORD COUNTY	PAXTON			
SETH GILLMAN	7.5	ASTA CARE CENTER OF PONTIAC	PONTIAC			
TAMAR MEISELMAN	7.5	ASTA CARE CENTER OF ROCKFORD	ROCKFORD	ASTA THERAPY		THERAPY
ALIZA FRANK	7.5	ASTA CARE CENTER OF TOLUCA	TOLUCA			

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		ASTA HEALTHCARE COMPANY, INC.		4,470	4,470	2
3	V	17	OFFICER'S SALARY -MG		ASTA HEALTHCARE COMPANY, INC.		31,473	31,473	3
4	V	17	ADMIN. SALARY -CF		ASTA HEALTHCARE COMPANY, INC.		26,358	26,358	4
5	V	17	ADMIN. SALARY -AF		ASTA HEALTHCARE COMPANY, INC.		5,350	5,350	5
6	V	19	PROFESSIONAL FEES		ASTA HEALTHCARE COMPANY, INC.		6,609	6,609	6
7	V	20	LICENSES & PERMITS		ASTA HEALTHCARE COMPANY, INC.		479	479	7
8	V	21	OFFICE EXPENSE		ASTA HEALTHCARE COMPANY, INC.		34,576	34,576	8
9	V	25	STAFF TRANS/ TRAVEL		ASTA HEALTHCARE COMPANY, INC.		6,273	6,273	9
10	V	27	PAYR. TAXES & W/C		ASTA HEALTHCARE COMPANY, INC.		5,926	5,926	10
11	V				ASTA HEALTHCARE COMPANY, INC.				11
12	V								12
13	V								13
14	Total			$ 180,000			$ 121,514	$ * (58,486)	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: 01/01/2013 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 OF ELGIN # 0041608 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						$		1
2			MANAGEMENT	40.00				SALARY	31,473	17-7	2
3											3
4	CRAIG FRANK	CFO	FINANCE/MGMT		SEE	SEE		SALARY	26,358	17-7	4
5	MANAGEMENT FEE FROM ASTA CARE OF FORD COUNTY $97,500				ATTACHED	ATTACHED					5
6	MANAGEMENT FEE FROM ASTA CARE OF COLFAX COUNTY $30,000				SCHEDULE	SCHEDULE					6
7											7
8	DAVID MEISELMAN	ADMINISTRATOR	ADMINISTRATIVE					SALARY	99,891	17-1	8
9	DAVID MEISELMAN	THERAPY MGMNT	MANAGEMENT					SALARY	23,036	39-3	9
10	ALIZA FRANK	PAYROLL CLERK	PAYROLL	7.50				SALARY	5,350	17-7	10
11											11
12											12
13								TOTAL	$ 186,108		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: 01/01/2013 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 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	191,321	7	$ 28,405	$ 28,303	30,107	$ 4,470	1
2	17	OFFICER'S SALARY -MG	PATIENT DAYS	191,321	7	200,000	200,000	30,107	31,473	2
3	17	ADMIN. SALARY -CF	PATIENT DAYS	191,321	7	167,500	167,500	30,107	26,358	3
4	17	ADMIN. SALARY -AF	PATIENT DAYS	191,321	7	34,000	34,000	30,107	5,350	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	191,321	7	42,001		30,107	6,609	5
6	20	LICENSES & PERMITS	PATIENT DAYS	191,321	7	3,043		30,107	479	6
7	21	OFFICE EXPENSE	PATIENT DAYS	191,321	7	219,718	184,734	30,107	34,576	7
8	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	191,321	7	39,861		30,107	6,273	8
9	27	PAYR. TAXES & W/C	PATIENT DAYS	191,321	7	37,656		30,107	5,926	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		$ 121,514	25

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	MEMBERS LOAN			WORKING CAPITAL			$	$			$ 1,696	1
2	N/P - SCHLUSSEL			WORKING CAPITAL	$1,594.00	9/1/10	75,000	33,227	9/1/15	10.0000	3,828	2
3	N/P - MEISELMAN			WORKING CAPITAL	$1,594.00	9/1/10	75,000	35,579	9/1/15	10.0000	3,641	3
4	N/P - PRINCE				$1,062.00	9/1/10	50,000	23,534	9/1/15	10.0000	2,597	4
5												5
	Working Capital											
6	ENLOE		X	TRADE PAYABLE FINANCE	$20,655.00		989,045	790,938			49,446	6
7	MARLIN		X	GENERATOR PURCHASE	$1,248.00	8/23/11	46,275	12,546	11/23/15	10.0000	5,640	7
8	MID CAP FINANCIAL		X	L.O.C	int	REVOLV		593,405			67,423	8
9	TOTAL Facility Related				$26,153.00		$ 1,235,320	$ 1,489,229			$ 134,271	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,235,320	$ 1,489,229			$ 134,271	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: 01/01/2013 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												3
4												4
5												5
	Working Capital											
6												6
7			X	INSURANCE POLICY FIN							2,502	7
8												8
9	TOTAL Facility Related						$	$			$ 2,502	9
	B. Non-Facility Related*											
10												10
11	HEALTHCARE FAMILY SVC			BED TAX INTEREST							4,178	11
12	MISC VENDORS										7,835	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 12,013	14
15	TOTALS (line 9+line14)						$	$			$ 14,515	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: 01/01/2013 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.**	$ 53,931	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.)		$ 49,389	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,541)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 49,389	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.		$ 44,848	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	84,942	8
	2009	89,907	9
	2010	56,520	10
	2011	53,931	11
	2012	49,389	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% 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 OF ELGIN COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0041608

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.	06-15-176-011	NURSING HOME	$ 42,820.34	$ 42,820.34
2.	06-15-176-043	NURSING HOME	$ 1,019.40	$ 1,019.40
3.	06-15-176-044	NURSING HOME	$ 5,549.52	$ 5,549.52
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 49,389.26	$ 49,389.26

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 OF ELGIN # 0041608 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOOR DRAIN			1997	1,297	33	39	33		546	9
10	INSTALL SHOWER VALVE AND DRAIN			1997	4,142	105	39	105		1,738	10
11	RE KEY DOOR LOCKS			1997	4,085	104	39	104		1,721	11
12	NEW AIR VENTS			1997	616	18	39	18		297	12
13	FIRE ALARM SYSTEM			1997	2,192	56	39	56		926	13
14	AWNINGS			1997	1,020	26	39	26		430	14
15	SEWAGE EJECTOR PUMP			1998	3,961	102	39	102		1,593	15
16	HOT WATER PUMP			1998	5,439	139	39	139		2,114	16
17	AWNINGS			1999	685	25	27.5	25		364	17
18	FLOORING			1999	2,474	90	27.5	90		1,309	18
19	ELECTRICAL WORK			1999	9,378	341	27.5	341		4,959	19
20	MAGNETIC DOOR LOCKS			1999	2,054	74	27.5	74		1,076	20
21	FIRE SPRINKLER SYSTEM			1999	3,868	141	27.5	141		2,050	21
22	BOILER			1999	4,890	178	27.5	178		2,588	22
23	NURSE STATION			2000	16,280	592	27.5	592		8,017	23
24	CONDENSING UNIT			2000	4,683	170	27.5	170		2,302	24
25	WATER HEATER			2000	8,731	317	27.5	317		4,293	25
26	POWER VENT FOR WATER HEATER			2000	2,682	98	27.5	98		1,327	26
27	NEW WALLS			2000	2,000	73	27.5	73		988	27
28	HOT WATER PIPING			2000	4,708	171	27.5	171		2,316	28
29	DRAPERIES			2000	2,303		7			2,303	29
30	EJECTOR PUMP			2001	14,041	511	27.5	511		6,409	30
31	ROOF			2001	6,218	226	27.5	226		2,834	31
32	COMPRESSOR			2001	3,501	127	27.5	127		1,593	32
33	PRESSURE BACK FLOW PREVENTER			2002	3,870	141	27.5	141		1,627	33
34	FIRE ALARM SYSTEM			2002	37,625	1,368	27.5	1,368		15,789	34
35	RE KEY LOCKS			2002	1,346	49	27.5	49		566	35
36	PATIENT SECURITY SYSTEM			2002	2,719	99	27.5	99		1,142	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: 01/01/2013 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	WATER HEATER	2002	$ 4,864	$ 177	27.5	$ 177	$	$ 2,043	37
38	NEW PIPE	2002	1,575	57	27.5	57		658	38
39	VINYL FLOORING	2002	17,779		5			17,779	39
40	HANDRAILS,BUMPERS,CORNER	2003	17,903	651	27.5	651		6,863	40
41	SMOKE DAMPERS	2003	1,904	69	27.5	69		727	41
42	DOOR ALARM SYSTEM	2003	3,097	113	27.5	113		1,191	42
43	SMOKING PORCH	2003	764	28	27.5	28		295	43
44	WALLCOVERINGS & PAINTING	2003	26,197		5			26,197	44
45	DIALYSIS ROOM	2004	23,267	846	27.5	846		8,072	45
46	VALVE ACTUATOR	2004	3,240	118	27.5	118		1,067	46
47	HOT WATER HEATER	2004	6,837	248	27.5	248		2,242	47
48	CURTAINS	2005	1,513		5			1,513	48
49	FIRE ALARM SYSTEM	2005	4,026	146	27.5	146		1,247	49
50	SPRINKLER HEADS	2005	2,530	92	27.5	92		786	50
51	FIRE DOOR	2005	547	20	27.5	20		171	51
52	ASPHALT	2005	6,000	400	15	400		3,417	52
53	ELEVATOR EMERGENCY STOP SWITCH	2006	1,849	67	27.5	67		505	53
54	PARKING LOT	2007	26,200	1,747	15	1,747		11,283	54
55	BOILER	2007	4,245	154	27.5	154		995	55
56	WATER HEATER	2007	6,453	235	27.5	235		1,517	56
57	NURSE CALL SYSTEM	2007	2,536	92	27.5	92		594	57
58	A/C CONDENSER	2007	5,928	216	27.5	216		1,395	58
59	5 TON A/C	2007	3,000	109	27.5	109		704	59
60	BLACK TOP AND SEAL THE PARKING LOT	2008	10,700	713	15	713		3,654	60
61	ROOF	2008	3,800	137	27.5	137		748	61
62	GENERATOR REPAIR	2008	4,578	168	27.5	168		917	62
63	EJECTOR PUMP	2009	3,125	114	27.5	114		508	63
64	CUSTOM CABINETS IN PT ROOM	2009	8,200	298	27.5	298		1,328	64
65	GENERATOR PANELS	2009	4,297	156	27.5	156		696	65
66	DISTRIBUTION PANEL	2010	9,758	355	27.5	355		1,227	66
67	WATER MAIN	2010	3,527	128	27.5	128		443	67
68	DOORS	2011	7,939	289	27.5	289		686	68
69	SPRINKLER SYSTEM	2011	5,285	192	27.5	192		440	69
70	TOTAL (lines 4 thru 69)		$ 390,271	$ 13,509		$ 13,509	$	$ 175,125	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: 01/01/2013 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	
1	Totals from Page 12A, Carried Forward		$ 390,271	$ 13,509		$ 13,509	$	$ 175,125	1
2	GENERATOR	2011	59,196	2,153	27.5	2,153		4,575	2
3	CURTAINS & BLINDS	2011	14,987		5	1,499	1,499	4,497	3
4	CUSTOM MILLWORK-60 DOORS REFACING	2013	9,900	137	27.5	137		137	4
5	CUSTOM MILLWORK-60 DOORS REFACING	2013	4,950	69	27.5	69		69	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 479,304	$ 15,868		$ 17,367	$ 1,499	$ 184,403	34

**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: 01/01/2013 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	$ 342,016	$ 2,812	$ 16,313	$ 13,501	10 YRS	$ 125,905	71
72	Current Year Purchases	4,325	2,595	216	(2,379)	10YRS	216	72
73	Fully Depreciated Assets	160,801					160,801	73
74								74
75	TOTALS	$ 507,142	$ 5,407	$ 16,529	$ 11,122		$ 286,922	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		MERCURY SABLE		$ 4,000	$ 800	$ 1,333	$ 533	3 YRS	$ 1,333	76
77										77
78										78
79										79
80	TOTALS			$ 4,000	$ 800	$ 1,333	$ 533		$ 1,333	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)	$ 990,446	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,075	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 35,229	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,154	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 472,658	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: 01/01/2013 Ending: 12/31/2013

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

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 26,286 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 OF ELGIN # 0041608 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 OF ELGIN # 0041608 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	$		$ 106,949	$		$ 106,949	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			20,204			20,204	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			445,158			445,158	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				225,302		225,302	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					57,689	3,428		57,689 3,428	13
14	TOTAL			$		$ 630,000	$ 228,730		$ 858,730	14

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

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	$ 82,749	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (84,500))	2,807,718		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,272		6
7	Other Prepaid Expenses	3,530		7
8	Accounts Receivable (owners or related parties)	112,099		8
9	Other(specify): Real Estate Escrow Deposit	105,658		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,168,026	$	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	416,525		15
16	Equipment, at Historical Cost	408,795		16
17	Accumulated Depreciation (book methods)	(534,157)		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 (spe Loan Costs	31,644		22
23	Other(specify): Security Deposits	16,895		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 339,702	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,507,728	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 956,385	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	804,058		29
30	Accrued Salaries Payable	157,335		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,370		31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,389		32
33	Accrued Interest Payable	3,232		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	456,549		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,444,318	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,338,144		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)**	$ 1,338,144	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,782,462	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (274,734)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,507,728	$	48

***(See instructions.)**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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**	$ (693,036)	1	
2	Restatements (describe):		2	
3	POST CLOSING ENTRIES	(11,092)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (704,128)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	429,394	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)**	$ 429,394	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)**	$ (274,734)	24	*

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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	$ 6,502,426	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,502,426	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	168,829	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 168,829	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***	2,357	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,357	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,673,612	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,184,004	31
32	Health Care	2,119,814	32
33	General Administration	1,214,003	33
	B. Capital Expense		
34	Ownership	722,785	34
	C. Ancillary Expense		
35	Special Cost Centers	858,730	35
36	Provider Participation Fee	214,825	36
	D. Other Expenses (specify):		
37			37
38	Penalty Abatement	(57,302)	38
39	OUT OF PERIOD EXPENSE ADJUSTMENT	(12,641)	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,244,218	40
41	**Income before Income Taxes (line 30 minus line 40)****	429,394	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 429,394	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,872,837	44
45	Private Pay - Net Inpatient Revenue	192,164	45
46	Medicare - Net Inpatient Revenue	2,372,377	46
47	Other-(specify) INSURANCE	65,048	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,502,426	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 OF ELGIN # 0041608 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	1,884	2,044	$ 90,870	$ 44.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,775	10,775	331,024	30.72	3
4	Licensed Practical Nurses	13,067	14,567	427,288	29.33	4
5	CNAs & Orderlies	53,378	54,989	649,293	11.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,909	8,384	133,051	15.87	8
9	Activity Director	3,119	3,392	66,043	19.47	9
10	Activity Assistants	6,858	7,417	81,603	11.00	10
11	Social Service Workers	3,899	4,227	102,559	24.26	11
12	Dietician					12
13	Food Service Supervisor	1,915	2,205	55,245	25.05	13
14	Head Cook	10,331	12,113	177,486	14.65	14
15	Cook Helpers/Assistants	6,841	7,069	66,051	9.34	15
16	Dishwashers					16
17	Maintenance Workers	1,922	2,214	57,082	25.78	17
18	Housekeepers	21,873	23,383	273,971	11.72	18
19	Laundry	6,005	6,647	73,543	11.06	19
20	Administrator	1,680	1,840	99,891	54.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,149	8,509	130,973	15.39	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	1,959	2,079	29,257	14.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	158,564	171,854	$ 2,845,230 *	$ 16.56	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	$ 8,927	1-3	35
36	Medical Director	O	7,500	9-3	36
37	Medical Records Consultant	N	3,630	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	7,632	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	1,390	11-3	44
45	Social Service Consultant	E	3,551	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,630		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 OF ELGIN # 0041608 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DAVID MEISELMAN	ADMINISTRATOR		$ 99,891
			0
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,891

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		102,678
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 102,678

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 130,012
Unemployment Compensation Insurance	60,986
FICA Taxes	215,425
Employee Health Insurance	33,017
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	5,153
EMPLOYEE PHYSICAL EXAMS	451
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)	$ 445,044

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,919
Health Care Worker Background Check	750
(Indicate # of checks performed 75)	
Patient Background Checks 109	1,094
TRUST/FRANCHISE/CONTRIB/ETC	600
MARKETING/ADV/PROMO	6,909
LICENSES/DUES/SUBSCRIPTIONS	4,968
MGMT CO ALLOC	479
TRUST/FRANCHISE/CONTRIB/ETC	(600)
Less: Public Relations Expense	(0)
Non-allowable advertising	(6,909)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,210

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,224
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,224

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 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 OF ELGIN # 0041608 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 HEALTH CARE ASSOCIATION $ 1,968**

(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. $ **7,582** 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. $ **214,825**
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.