

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0041608</u></p> <p>Facility Name: <u>ASTA CARE CENTER OF ELGIN</u></p> <p>Address: <u>134 NORTH MCCLEAN BOULEVARD ELGIN 60123</u> Number City Zip Code</p> <p>County: <u>KANE</u></p> <p>Telephone Number: <u>(847) 742-8822</u> Fax # <u>(847) 742-9013</u></p> <p>HFS ID Number: <u>36-4069629</u></p> <p>Date of Initial License for Current Owners: <u>03/29/96</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MICHAEL GILLMAN</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> </tr> <tr> <td rowspan="4" style="width: 20%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MICHAEL GILLMAN</u> (Date) _____		(Title) <u>MEMBER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	52	Skilled (SNF)	52	18,980	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,230	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,329	100	5,020	7,449	8
9	SNF/PED					9
10	ICF	23,014	881	315	24,210	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,343	981	5,335	31,659	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.04%

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 03/29/96

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

YES Date 06/29/96 NO

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

YES NO If YES, enter number of beds certified 52 and days of care provided 4,063

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number

ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	278,687	29,066	12,637	320,390		320,390		320,390		1
2	Food Purchase		189,997		189,997		189,997	(4,791)	185,206		2
3	Housekeeping	275,035	26,220		301,255		301,255		301,255		3
4	Laundry	66,014	11,977		77,991		77,991		77,991		4
5	Heat and Other Utilities			109,504	109,504		109,504		109,504		5
6	Maintenance	57,361	29,539	41,093	127,993		127,993	1,315	129,308		6
7	Other (specify):*			36,355	36,355		36,355		36,355		7
8	TOTAL General Services	677,097	286,799	199,589	1,163,485		1,163,485	(3,476)	1,160,009		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,376,968	130,036	2,136	1,509,140		1,509,140	2,307	1,511,447		10
10a	Therapy	132,429	3,531		135,960		135,960		135,960		10a
11	Activities	137,024	30,055	4,659	171,738		171,738		171,738		11
12	Social Services	94,434		2,607	97,041		97,041		97,041		12
13	CNA Training										13
14	Program Transportation			981	981		981		981		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,740,855	163,622	19,383	1,923,860		1,923,860	2,307	1,926,167		16
	C. General Administration										
17	Administrative	246,167		195,000	441,167		441,167	(103,778)	337,389		17
18	Directors Fees										18
19	Professional Services			98,697	98,697		98,697	(1,928)	96,769		19
20	Dues, Fees, Subscriptions & Promotions			22,571	22,571		22,571	(11,051)	11,520		20
21	Clerical & General Office Expenses	129,748	26,467	70,309	226,524		226,524	(12,672)	213,852		21
22	Employee Benefits & Payroll Taxes			346,808	346,808		346,808		346,808		22
23	Inservice Training & Education										23
24	Travel and Seminar			910	910		910	49	959		24
25	Other Admin. Staff Transportation			4,088	4,088		4,088	4,808	8,896		25
26	Insurance-Prop.Liab.Malpractice			86,103	86,103		86,103	1,636	87,739		26
27	Other (specify):*			50,749	50,749		50,749	(42,737)	8,012		27
28	TOTAL General Administration	375,915	26,467	875,235	1,277,617		1,277,617	(165,673)	1,111,944		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,793,867	476,888	1,094,207	4,364,962		4,364,962	(166,842)	4,198,120		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	9,277
	REPAIRS & MAINTENANCE	1,741
	OUTSIDE SERVICES	1,619
		12,637
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	26,681
	ELECTRICITY	44,292
	WATER	38,251
	CABLE TV - LOBBY	280
		0
		109,504
6	MAINTENANCE	
	GROUNDS MAINTENANCE	346
	PAINTING & DECORATING	0
	BUILDING REPAIRS	2,039
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	24,718
	ELEVATOR MAINTENANCE & REPAIR	2,103
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,375
	FIRE SERVICE	6,899
	PAINTING & DECORATING	1,613
		0
		0
		0
		41,093
7	OTHER	
	SCAVENGER	35,608
	SECURITY SERVICE	747
		0
		0
		36,355
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,000
		9,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,536
	PHARMACY CONSULTANT XVIII B 39-2	600
	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
		2,136
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,659
		0
		4,659
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	496
	SOCIAL WORKER XVIII B 45-2	2,111
		0
		2,607
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	981	981
		0	
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 195,000	195,000
	DIRECTORS FEES		
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 14,596	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 84,101	
		0	98,697
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 9,888	
	EMPLOYEE WANT ADS	XIX F 1,395	
	CONTRIBUTIONS	VI 20 XIX F 400	
	DUES & SUBSCRIPTIONS	XIX F 4,267	
	LICENSES & PERMITS	XIX F 2,595	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 1,933	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 1,000	
	PATIENT BACKGROUND CHECKS	XIX F 1,093	
			22,571
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	6,777	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 28,022	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	29,000	
	MESSENGER SERVICE	3,369	
	OUTSIDE BOOKKEEPING SERVICES	3,141	70,309

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 204,620	
	UNEMPLOYMENT COMPENSATION	XIX D 25,746	
	WORKERS COMPENSATION INSURANC	XIX D 59,228	
	HOSPITALIZATION INSURANCE	XIX D 54,769	
	EMPLOYEE BENEFITS - OTHER	XIX D 0	
	EMPLOYEE PHYSICAL EXAMS	XIX D 2,445	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	
		0	346,808
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	0	
			0
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 910	
	TRAVEL	XIX G 0	
			910
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	4,088	
			4,088
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	86,103	
			86,103
27	OTHER		
	BAD DEBTS	VI 24 50,749	
			50,749

GRAND TOTAL COLUMN 3 OTHER **1,094,207**

ASTA CARE CENTER OF ELGIN
SCHEDULES
12/31/2009

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

TOTAL FOOD PURCHASE	189,997
LESS SALES TAX	<u>(4,791)</u>
NET FOOD	185,206

TOTAL PATIENT CENSUS	31,659
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	94,977

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	94,977
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	94,977

NET FOOD	185,206
DIVIDE TOTAL MEALS/YEAR	<u>94,977</u>

COST PER MEAL	1.95
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number ASTA CARE CENTER OF ELGIN

#0041608

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			31,316	31,316		31,316	(504)	30,812			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			72,653	72,653		72,653	(5,714)	66,939			32
33	Real Estate Taxes			85,939	85,939		85,939		85,939			33
34	Rent-Facility & Grounds			464,280	464,280		464,280		464,280			34
35	Rent-Equipment & Vehicles			28,908	28,908		28,908		28,908			35
36	Other (specify):*											36
37	TOTAL Ownership			683,096	683,096		683,096	(6,218)	676,878			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		177,859	563,074	740,933		740,933		740,933			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		177,859	618,919	796,778		796,778		796,778			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,793,867	654,747	2,396,222	5,844,836		5,844,836	(173,060)	5,671,776			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: 01/01/2009

Ending: 12/31/2009

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(504)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,791)	2		13
14	Non-Care Related Interest	(5,714)	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	(28,022)	21		18
19	Entertainment		20		19
20	Contributions	(2,333)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,197)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,749)	27		24
25	Fund Raising, Advertising and Promotional	(9,888)	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	(40,885)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (145,083)		\$	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	2	
		Amount	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)	(27,977)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (27,977)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (173,060)		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	2	3	4	
		Yes	No	Amount	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 OF ELGIN

ID# 0041608

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

Reference

NON-ALLOWABLE EXPENSES

Amount

		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 409	6	1
2	MARKETING SALARY	(23,435)	21	2
3	NON ALLOWABLE TRAVEL	(2,859)	25	3
4	DAVID MEISELMAN- MANAGEMENT FEE	(15,000)	17	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		(40,885)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,791)	0	0	0	0	0	0	0	0	0	0	(4,791)	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	409	906	0	0	0	0	0	0	0	0	0	1,315	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,382)	906	0	(3,476)	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	2,307	0	0	0	0	0	0	0	0	0	2,307	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	2,307	0	2,307	16								
	C. General Administration													
17	Administrative	(15,000)	(88,778)	0	0	0	0	0	0	0	0	0	(103,778)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,197)	269	0	0	0	0	0	0	0	0	0	(1,928)	19
20	Fees, Subscriptions & Promotions	(12,221)	1,170	0	0	0	0	0	0	0	0	0	(11,051)	20
21	Clerical & General Office Expenses	(51,457)	38,785	0	0	0	0	0	0	0	0	0	(12,672)	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	49	0	0	0	0	0	0	0	0	0	49	24
25	Other Admin. Staff Transportation	(2,859)	7,667	0	0	0	0	0	0	0	0	0	4,808	25
26	Insurance-Prop.Liab.Malpractice	0	1,636	0	0	0	0	0	0	0	0	0	1,636	26
27	Other (specify):*	(50,749)	8,012	0	0	0	0	0	0	0	0	0	(42,737)	27
28	TOTAL General Administration	(134,483)	(31,190)	0	(165,673)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(138,865)	(27,977)	0	(166,842)	29								

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(504)	0	0	0	0	0	0	0	0	0	0	(504)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,714)	0	0	0	0	0	0	0	0	0	0	(5,714)	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	(6,218)	0	0	0	0	0	0	0	0	0	0	(6,218)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(145,083)	(27,977)	0	0	0	0	0	0	0	0	0	(173,060)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	6 MAINTENANCE				906	906	2
3	V	10 NURSING				2,307	2,307	3
4	V	17 ADMINISTRATIVE				91,222	91,222	4
5	V	19 PROFESSIONAL FEES				269	269	5
6	V	20 LICENSES & PERMITS				1,170	1,170	6
7	V	21 OFFICE EXPENSE				38,785	38,785	7
8	V	24 SEMINARS				49	49	8
9	V	25 STAFF TRANS/ TRAVEL				7,667	7,667	9
10	V	26 INSURANCE GEN / WC				1,636	1,636	10
11	V	27 PAYR. TAXES & GRP INS				8,012	8,012	11
12	V							12
13	V							13
14	Total		\$ 180,000			\$ 152,023	\$ * (27,977)	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: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN							SALARY	\$ 34,598	17-7	1
2											2
3	SETH GILLMAN							SALARY	1,199	17-7	3
4											4
5					SEE		SEE				5
6					ATTACHED		ATTACHED				6
7	CRAIG FRANK				SCHEDULE		SCHEDULE	SALARY	29,165	17-7	7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$43,333										8
9											9
10	DAVID MEISELMAN										10
11	SALARY FROM ASTA CARE OF ELGIN \$246,167							SALARY	246,167	17-1	11
12	ALIZA FRANK							SALARY	6,033	17-7	12
13								TOTAL	\$ 317,162		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:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization ASTA HEALTHCARE 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PATIENT DAYS	178,434	6	\$ 5,107	\$ 31,659	\$ 906	1
2	10	NURSING	PATIENT DAYS	178,434	6	13,000	13,000	2,307	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	178,434	6	195,000	195,000	34,598	3
4	17	OFFICER'S SALARY - SETH	PATIENT DAYS	178,434	6	6,755	6,755	1,199	4
5	17	ADMIN. SALARY -CF	PATIENT DAYS	178,434	6	164,375	164,375	29,165	5
6	17	ADMIN. SALARY -AF	PATIENT DAYS	178,434	6	34,000	34,000	6,033	6
7	17	ADMIN. SALARY- JS	PATIENT DAYS	178,434	6	114,000	114,000	20,227	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	178,434	6	1,518	31,659	269	8
9	20	LICENSES & PERMITS	PATIENT DAYS	178,434	6	6,596	31,659	1,170	9
10	21	OFFICE EXPENSE	PATIENT DAYS	178,434	6	218,597	139,019	38,785	10
11	24	SEMINARS	PATIENT DAYS	178,434	6	275	31,659	49	11
12	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	178,434	6	43,211	31,659	7,667	12
13	26	INSURANCE GEN / WC	PATIENT DAYS	178,434	6	9,222	31,659	1,636	13
14	27	PAYR. TAXES & GRP INS	PATIENT DAYS	178,434	6	45,157	31,659	8,012	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 856,813	\$ 666,149	\$ 152,023	25

Facility Name & ID Number

ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	Name of Lender	2		3	4	5	6		8	9	10	Reporting Period Interest Expense				
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO										Original	Balance		
A. Directly Facility Related																
Long-Term																
1							\$	\$			\$	1				
2												2				
3												3				
4												4				
5	ELGIN NURSING HOME-PROP.	X										32,923	5			
Working Capital																
6	FIRST CHICAGO BANK & TRUST	X		WORKING CAPITAL	INT	REVOLV		595,475	REVOLV	0.0375		26,769	6			
7	HARRIS BANK-MEMBER			WORKING CAPITAL								2,214	7			
8	INSURANCE POLICIES		X									5,033	8			
9	TOTAL Facility Related						\$	\$ 595,475			\$	66,939	9			
B. Non-Facility Related*																
10													10			
11	BED TAX											5,586	11			
12	MISC											128	12			
13													13			
14	TOTAL Non-Facility Related						\$	\$			\$	5,714	14			
15	TOTALS (line 9+line14)						\$	\$ 595,475			\$	72,653	15			

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.		\$	83,946	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.)		\$	84,942	2
3. Under or (over) accrual (line 2 minus line 1).		\$	997	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	84,942	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.		\$	85,939	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	75,184	8	
	2005	80,254	9	
	2006	84,432	10	
	2007	83,945	11	
	2008	84,942	12	

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF ELGIN COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0041608

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>06-15-176-011</u>	<u>NURSING HOME</u>	\$ <u>77,596.12</u>	\$ <u>77,596.12</u>
2.	<u>06-15-176-043</u>	<u>NURSING HOME</u>	\$ <u>986.00</u>	\$ <u>986.00</u>
3.	<u>06-15-176-044</u>	<u>NURSING HOME</u>	\$ <u>6,360.20</u>	\$ <u>6,360.20</u>

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>84,942.32</u>	\$ <u>84,942.32</u>

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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **ASTA CARE CENTER OF ELGIN**# **0041608**

Report Period Beginning:

01/01/2009

Ending:

12/31/2009**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		FLOOR DRAIN	1997		1,297	33	39	33		414	9
10		INSTALL SHOWER VALVE AND DRAIN	1997		4,142	105	39	105		1,318	10
11		RE KEY DOOR LOCKS	1997		4,085	104	39	104		1,305	11
12		NEW AIR VENTS	1997		616	18	39	18		225	12
13		FIRE ALARM SYSTEM	1997		2,192	56	39	56		702	13
14		AWNINGS	1997		1,020	26	39	26		326	14
15		SEWAGE EJECTOR PUMP	1998		3,961	102	39	102		1,185	15
16		HOT WATER PUMP	1998		5,439	139	39	139		1,558	16
17		AWNINGS	1999		685	25	27.5	25		264	17
18		FLOORING	1999		2,474	90	27.5	90		949	18
19		ELECTRICAL WORK	1999		9,378	341	27.5	341		3,595	19
20		MAGNETIC DOOR LOCKS	1999		2,054	74	27.5	74		780	20
21		FIRE SPRINKLER SYSTEM	1999		3,868	141	27.5	141		1,486	21
22		BOILER	1999		4,890	178	27.5	178		1,876	22
23		NURSE STATION	2000		16,280	592	27.5	592		5,649	23
24		CONDENSING UNIT	2000		4,683	170	27.5	170		1,622	24
25		WATER HEATER	2000		8,731	317	27.5	317		3,025	25
26		POWER VENT FOR WATER HEATER	2000		2,682	98	27.5	98		935	26
27		NEW WALLS	2000		2,000	73	27.5	73		696	27
28		HOT WATER PIPING	2000		4,708	171	27.5	171		1,632	28
29		DRAPERIES	2000		2,303		7			2,303	29
30		EJECTOR PUMP	2001		14,041	511	27.5	511		4,365	30
31		ROOF	2001		6,218	226	27.5	226		1,930	31
32		COMPRESSOR	2001		3,501	127	27.5	127		1,085	32
33		PRESSURE BACK FLOW PREVENTER	2002		3,870	141	27.5	141		1,063	33
34		FIRE ALARM SYSTEM	2002		37,625	1,368	27.5	1,368		10,317	34
35		RE KEY LOCKS	2002		1,346	49	27.5	49		370	35
36		PATIENT SECURITY SYSTEM	2002		2,719	99	27.5	99		746	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:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WATER HEATER	2002	\$ 4,864	\$ 177	27.5	\$ 177		\$ 1,335	37
38	NEW PIPE	2002	1,575	57	27.5	57		430	38
39	VINYL FLOORING	2002	17,779		5			17,779	39
40	HANDRAILS,BUMPERS,CORNER	2003	17,903	651	27.5	651		4,259	40
41	SMOKE DAMPERS	2003	1,904	69	27.5	69		451	41
42	DOOR ALARM SYSTEM	2003	3,097	113	27.5	113		739	42
43	SMOKING PORCH	2003	764	28	27.5	28		183	43
44	WALLCOVERINGS & PAINTING	2003	26,197		5			26,197	44
45	DIALYSIS ROOM	2004	23,267	846	27.5	846		4,688	45
46	VALVE ACTUATOR	2004	3,240	118	27.5	118		595	46
47	HOT WATER HEATER	2004	6,837	248	27.5	248		1,250	47
48	CURTAINS	2005	1,513	174	5	241	67	1,513	48
49	FIRE ALARM SYSTEM	2005	4,026	146	27.5	146		663	49
50	SPRINKLER HEADS	2005	2,530	92	27.5	92		418	50
51	FIRE DOOR	2005	547	20	27.5	20		91	51
52	ASPHALT	2005	6,000	400	15	400		1,817	52
53	ELEVATOR EMERGENCY STOP SWITCH	2006	1,849	67	27.5	67		237	53
54	PARKING LOT	2007	26,200	1,747	15	1,747		4,295	54
55	BOILER	2007	4,245	154	27.5	154		379	55
56	WATER HEATER	2007	6,453	235	27.5	235		577	56
57	NURSE CALL SYSTEM	2007	2,536	92	27.5	92		226	57
58	A/C CONDENSER	2007	5,928	216	27.5	216		531	58
59	5 TON A/C	2007	3,000	109	27.5	109		268	59
60	BLACK TOP AND SEAL THE PARKING LOT	2008	10,700	713	15	713		802	60
61	ROOF	2008	3,800	137	27.5	137		200	61
62	GENERATOR REPAIR	2008	4,578	168	27.5	168		245	62
63	EJECTOR PUMP	2009	3,125	52	27.5	52		52	63
64	CUSTOM CABINETS IN PT ROOM	2009	8,200	136	27.5	136		136	64
65	GENERATOR PANELS	2009	4,297	72	27.5	72		72	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 363,762	\$ 12,411		\$ 12,478	\$ 67	\$ 122,149	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 185,710	\$ 11,261	\$ 17,697	\$ 6,436	10 YRS	\$ 107,177	71
72	Current Year Purchases	12,739	7,644	637	(7,007)	10 YRS	637	72
73	Fully Depreciated Assets	106,596					106,596	73
74								74
75	TOTALS	\$ 305,045	\$ 18,905	\$ 18,334	\$ (571)		\$ 214,410	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 668,807	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,316	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,812	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (504)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 336,559	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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. 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:	<u>102</u>		\$ <u>464,280</u>			3
4	Additions						4
5							5
6							6
7	TOTAL	102		\$ 464,280			7

10. Effective dates of current rental agreement:

Beginning 3/26/96

Ending 3/26/26

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2010 \$ 464,280

13. /2011 \$ 464,280

14. /2012 \$ 464,280

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 18,015 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	<u>AMINISTRATOR</u>	<u>VDUO X 90</u>	\$ <u>637.00</u>	\$	17
18	<u>AMINISTRATOR</u>	<u>LINCOLN</u>	<u>777.00</u>	<u>10,893</u>	18
19					19
20					20
21	TOTAL		\$ #####	\$ 10,893	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: 01/01/2009 Ending: 12/31/2009
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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 130,925	\$		\$ 130,925	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			45,977			45,977	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			278,954			278,954	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 prescripts				174,001		174,001	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>I.V. Therapy, Med. Supplies</u>					<u>107,218</u>	3,858		<u>107,218</u> 3,858	13
14	TOTAL			\$		\$ 563,074	\$ 177,859		\$ 740,933	14

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN# 0041608Report Period Beginning: 01/01/2009

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 61,428	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,167,546		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,220		6
7	Other Prepaid Expenses	2,693		7
8	Accounts Receivable (owners or related parties)	347,644		8
9	Other(specify): <u>Real Estate Escrow Deposit</u>	17,677		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,643,208	\$	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	315,970		15
16	Equipment, at Historical Cost	352,837		16
17	Accumulated Depreciation (book methods)	(408,815)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Security Deposits</u>	16,895		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 276,887	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,920,095	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,448,900	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	595,475		29
30	Accrued Salaries Payable	122,084		30
31	Accrued Taxes Payable (excluding real estate taxes)	123,316		31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,942		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,374,717	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Member Loans</u>	730,264		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 730,264	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,104,981	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,184,886)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,920,095	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (934,945)	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (934,946)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(249,940)	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)	\$ (249,940)	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)	\$ (1,184,886)	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,218,631	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,218,631	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	276,502	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 276,502	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	100,000	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)	\$ 100,000	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)		26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,595,133	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,163,485	31
32	Health Care	1,923,860	32
33	General Administration	1,277,617	33
B. Capital Expense			
34	Ownership	683,096	34
C. Ancillary Expense			
35	Special Cost Centers	740,933	35
36	Provider Participation Fee	55,845	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,844,836	40
41	Income before Income Taxes (line 30 minus line 40)**	(249,703)	41
42	Income Taxes	(237)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (249,940)	43

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

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

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

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

Facility Name & ID Number **ASTA CARE CENTER OF ELGIN**

0041608

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,061	2,216	\$ 88,783	\$ 40.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,962	8,762	285,084	32.54	3
4	Licensed Practical Nurses	13,195	14,362	410,200	28.56	4
5	CNAs & Orderlies	47,868	49,088	550,397	11.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,040	6,388	132,429	20.73	8
9	Activity Director	2,004	2,269	42,299	18.64	9
10	Activity Assistants	9,333	9,884	94,725	9.58	10
11	Social Service Workers	4,709	5,194	94,434	18.18	11
12	Dietician	1,910	2,254	54,830	24.33	12
13	Food Service Supervisor					13
14	Head Cook	12,848	14,255	187,356	13.14	14
15	Cook Helpers/Assistants	3,893	4,058	36,501	8.99	15
16	Dishwashers					16
17	Maintenance Workers	2,062	2,330	57,361	24.62	17
18	Housekeepers	22,926	24,966	275,035	11.02	18
19	Laundry	6,383	6,950	66,014	9.50	19
20	Administrator	2,107	2,107	246,167	116.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,669	6,198	129,748	20.93	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	1,739	2,086	42,504	20.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,709	163,367	\$ 2,793,867 *	\$ 17.10	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	MONTHLY \$ 9,277	1-3	35	
36	Medical Director	MONTHLY 9,000	9-3	36	
37	Medical Records Consultant	QUARTERLY 1,536	10-3	37	
38	Nurse Consultant	0	10-3	38	
39	Pharmacist Consultant	MONTHLY 600	10-3	39	
40	Physical Therapy Consultant	0	10a-3	40	
41	Occupational Therapy Consultant	0	10a-3	41	
42	Respiratory Therapy Consultant	0	10a-3	42	
43	Speech Therapy Consultant	0	10a-3	43	
44	Activity Consultant	54	4,659	11-3	44
45	Social Service Consultant	44	2,607	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	98	\$ 27,679		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
DAVID MEISELMAN	ADMINISTRATOR		\$ 246,167	Workers' Compensation Insurance	\$ 59,228	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	25,746	Advertising: Employee Recruitment	1,395	
			0	FICA Taxes	204,620	Health Care Worker Background Check	1,000	
				Employee Health Insurance	54,769	(Indicate # of checks performed <u>100</u>)		
				Employee Meals	0	Patient Background Checks <u>109</u>	1,093	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	2,333	
				EMPLOYEE BENEFITS - OTHER	0	MARKETING/ADV/PROMO	9,888	
				EMPLOYEE PHYSICAL EXAMS	2,445	LICENSES/DUES/SUBSCRIPTIONS	6,862	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	1,170	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(2,333)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(9,888)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 246,167	TOTAL (agree to Schedule V, line 22, col.8)	\$ 346,808	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,520	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
ASTA HEALTHCARE MANAGEMENT, INC			\$ 180,000				Out-of-State Travel	\$
DAVID MEISELMAN			15,000					
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 195,000				Seminar Expense	910
							MGMT CO ALLOC	49
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 959
			\$					
SEE SCHEDULE ATTACHED			98,697					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 98,697	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	2006	\$ 2,457	3 YRS	\$ 410	\$ 819	\$ 819	\$ 409	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
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11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 2,457		\$ 410	\$ 819	\$ 819	\$ 409	\$	\$	\$	\$

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

0041608

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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 ASSOC. \$5815
- (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. \$ 21,063 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES _____ NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,845
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.