



Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY

# 0045823 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	69	Skilled (SNF)	69	25,185	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	69	TOTALS	69	25,185	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,659	764	2,321	10,744	8
9	SNF/PED					9
10	ICF	9,360	510	43	9,913	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,019	1,274	2,364	20,657	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.02%

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 07/01/02

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 17 and days of care provided 2,321

Medicare Intermediary ADMINISTAR OF ILLINOIS

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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
	<b>A. General Services</b>										
1	Dietary	187,664	11,306	5,060	204,030		204,030		204,030		1
2	Food Purchase		117,417		117,417		117,417	(1,541)	115,876		2
3	Housekeeping	129,496	17,805		147,301		147,301		147,301		3
4	Laundry	4,872	5,055		9,927		9,927		9,927		4
5	Heat and Other Utilities			94,748	94,748		94,748	86	94,834		5
6	Maintenance	34,177	8,134	24,441	66,752		66,752	247	66,999		6
7	Other (specify):*			4,021	4,021		4,021		4,021		7
8	<b>TOTAL General Services</b>	<b>356,209</b>	<b>159,717</b>	<b>128,270</b>	<b>644,196</b>		<b>644,196</b>	<b>(1,208)</b>	<b>642,988</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	896,729	92,192	55,359	1,044,280		1,044,280	373	1,044,653		10
10a	Therapy										10a
11	Activities	45,525	11,192	1,776	58,493		58,493		58,493		11
12	Social Services	13,569		864	14,433		14,433		14,433		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>955,823</b>	<b>103,384</b>	<b>57,999</b>	<b>1,117,206</b>		<b>1,117,206</b>	<b>373</b>	<b>1,117,579</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	92,847		5,315	98,162		98,162	97,065	195,227		17
18	Directors Fees										18
19	Professional Services			53,802	53,802		53,802	1,035	54,837		19
20	Dues, Fees, Subscriptions & Promotions			22,289	22,289		22,289	(9,390)	12,899		20
21	Clerical & General Office Expenses	85,618	12,010	53,050	150,678		150,678	(32,530)	118,148		21
22	Employee Benefits & Payroll Taxes			214,427	214,427		214,427		214,427		22
23	Inservice Training & Education										23
24	Travel and Seminar			639	639		639	368	1,007		24
25	Other Admin. Staff Transportation			23,345	23,345		23,345	(16,116)	7,229		25
26	Insurance-Prop.Liab.Malpractice			65,647	65,647		65,647	1,290	66,937		26
27	Other (specify):*			69,080	69,080		69,080	(62,493)	6,587		27
28	<b>TOTAL General Administration</b>	<b>178,465</b>	<b>12,010</b>	<b>507,594</b>	<b>698,069</b>		<b>698,069</b>	<b>(20,771)</b>	<b>677,298</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,490,497</b>	<b>275,111</b>	<b>693,863</b>	<b>2,459,471</b>		<b>2,459,471</b>	<b>(21,606)</b>	<b>2,437,865</b>		<b>29</b>

\*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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	5,060
	REPAIRS & MAINTENANCE	0
		0
		5,060
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	24,541
	ELECTRICITY	40,987
	WATER	29,220
	CABLE TV - LOBBY	0
		0
		94,748
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	7,179
	PAINTING & DECORATING	0
	BUILDING REPAIRS	1,263
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	10,972
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	900
	FIRE SERVICE	4,127
		0
		0
		0
		0
		24,441
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	4,021
	SECURITY SERVICE	0
		0
		0
		4,021
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	0
		0

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	37,411
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	2,208
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	1,540
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	4,700
	PSYCHIATRIC XVIII B ___-2	9,500
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		55,359
<b>10a</b>	<b>THERAPY</b>	
	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 CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,776
		0
		1,776
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	864
	SOCIAL WORKER XVIII B 45-2	0
		0
		864
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	5,315
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	13,299
	ADMINISTRATIVE CONSULTANTS XIX C	930
	PROFESSIONAL FEES XIX C	39,573
		0
		53,802
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	8,604
	EMPLOYEE WANT ADS XIX F	2,780
	CONTRIBUTIONS VI 20 XIX F	1,400
	DUES & SUBSCRIPTIONS XIX F	3,792
	LICENSES & PERMITS XIX F	3,813
	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	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	700
	PATIENT BACKGROUND CHECKS XIX F	1,200
		22,289
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,409
	EQUIPMENT REPAIR & MAINTENANCE	7,667
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	27,773
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	287
	TELEPHONE	14,914
	MESSENGER SERVICE	0
		0
		53,050

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	111,009
	UNEMPLOYMENT COMPENSATION XIX D	27,098
	WORKERS COMPENSATION INSURANC XIX D	54,448
	HOSPITALIZATION INSURANCE XIX D	20,176
	EMPLOYEE BENEFITS - OTHER XIX D	1,658
	EMPLOYEE PHYSICAL EXAMS XIX D	38
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		214,427
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	639
	TRAVEL XIX G	0
		639
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	23,345
		23,345
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	65,647
		65,647
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	69,080
		69,080

GRAND TOTAL COLUMN 3 OTHER

693,863

**ASTA CARE CENTER-FORD COUNTY  
SCHEDULES  
12/31/2007**

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

TOTAL FOOD PURCHASE	117,417
LESS SALES TAX	<u>(1,541)</u>
NET FOOD	115,876

TOTAL PATIENT CENSUS	20,657
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	61,971

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

PATIENT MEALS	61,971
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	61,971

NET FOOD	115,876
DIVIDE TOTAL MEALS/YEAR	<u>61,971</u>

COST PER MEAL	1.87
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY

#0045823

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	
	<b>D. Ownership</b>											
30	Depreciation			18,100	18,100		18,100	(6,548)	11,552			30
31	Amortization of Pre-Op. & Org.			8,625	8,625		8,625		8,625			31
32	Interest			48,525	48,525		48,525	(3,534)	44,991			32
33	Real Estate Taxes			30,144	30,144		30,144		30,144			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	168,500	300,500			34
35	Rent-Equipment & Vehicles			8,415	8,415		8,415	356	8,771			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			245,809	245,809		245,809	158,774	404,583			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,987	293,649	387,636		387,636		387,636			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,778	37,778		37,778		37,778			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		93,987	331,427	425,414		425,414		425,414			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,490,497	369,098	1,271,099	3,130,694		3,130,694	137,168	3,267,862			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(6,548)	30		9
10	Interest and Other Investment Income	(38)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,541)	2		13
14	Non-Care Related Interest	(3,496)	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	(27,773)	21		18
19	Entertainment		20		19
20	Contributions	(1,400)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(39)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(69,080)	27		24
25	Fund Raising, Advertising and Promotional	(8,604)	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	(32,979)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (151,498)</b>		<b>\$</b>	<b>30</b>

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	288,666		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 288,666</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ 137,168</b>		<b>37</b>

\*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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

ASTA CARE CENTER-FORD COUNTY

ID# 0045823

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3	STAFF TRANS -NONALLOW	(19,958)	25	3
4	MARKETING SALARIES	(13,021)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(32,979)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY# 0045823

Report Period Beginning:

01/01/2007

Ending:

12/31/2007**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	(1,541)	0	0	0	0	0	0	0	0	0	0	(1,541)	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	86	0	0	0	0	0	0	0	0	0	86	5
6	Maintenance	0	247	0	0	0	0	0	0	0	0	0	247	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,541)</b>	<b>333</b>	<b>0</b>	<b>(1,208)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	373	0	0	0	0	0	0	0	0	0	373	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>373</b>	<b>0</b>	<b>373</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	97,065	0	0	0	0	0	0	0	0	0	97,065	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(39)	1,074	0	0	0	0	0	0	0	0	0	1,035	19
20	Fees, Subscriptions & Promotions	(10,004)	614	0	0	0	0	0	0	0	0	0	(9,390)	20
21	Clerical & General Office Expenses	(40,794)	8,264	0	0	0	0	0	0	0	0	0	(32,530)	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	368	0	0	0	0	0	0	0	0	0	368	24
25	Other Admin. Staff Transportation	(19,958)	3,842	0	0	0	0	0	0	0	0	0	(16,116)	25
26	Insurance-Prop.Liab.Malpractice	0	1,290	0	0	0	0	0	0	0	0	0	1,290	26
27	Other (specify):*	(69,080)	6,587	0	0	0	0	0	0	0	0	0	(62,493)	27
28	<b>TOTAL General Administration</b>	<b>(139,875)</b>	<b>119,104</b>	<b>0</b>	<b>(20,771)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(141,416)</b>	<b>119,810</b>	<b>0</b>	<b>(21,606)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY# 0045823

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	(6,548)	0	0	0	0	0	0	0	0	0	0	(6,548)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,534)	0	0	0	0	0	0	0	0	0	0	(3,534)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	168,500	0	0	0	0	0	0	0	0	168,500	34
35	Rent-Equipment & Vehicles	0	356	0	0	0	0	0	0	0	0	0	356	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(10,082)</b>	<b>356</b>	<b>168,500</b>	<b>0</b>	<b>158,774</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(151,498)</b>	<b>120,166</b>	<b>168,500</b>	<b>0</b>	<b>137,168</b>	<b>45</b>							

**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 PAXTON	ELGIN	LANDLORD
				PROPERTIES		
				ASTA THERAPY	ELGIN	THERAPY

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	MANAGEMENT FEE	\$ 5,315	ASTA HEALTHCARE COMPANY		\$	(5,315)	1
2	V	5	UTILITIES			86		86	2
3	V	6	MAINTENANCE			247		247	3
4	V	10	NURSING			373		373	4
5	V	17	ADMINISTRATIVE			102,380		102,380	5
6	V	19	PROFESSIONAL FEES			1,074		1,074	6
7	V	20	LICENSES & PERMITS			614		614	7
8	V	21	OFFICE EXPENSE			8,264		8,264	8
9	V	24	SEMINARS			368		368	9
10	V	25	STAFF TRANS/ TRAVEL			3,842		3,842	10
11	V	26	INSURANCE GEN / WC			1,290		1,290	11
12	V	27	PAYR. TAXES & GRP INS			6,587		6,587	12
13	V	35	EQUIPMENT RENTAL			356		356	13
14	Total		\$ 5,315			\$ 125,481	\$ *	120,166	14

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 RENT	\$ 132,000	ASTA PAXTON PROPERTIES		\$	(132,000)	15
16	V	34 RENT				300,500	300,500	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 132,000			\$ 300,500	\$ * 168,500	39

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

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY # 0045823 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## 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			60.00		LIST	ATTACHED	SALARY	\$ 18,314	17-7	1
2	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										2
3	SETH GILLMAN			10.00		LIST	ATTACHED	SALARY	18,314	17-7	3
4	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										4
5	SALARY FROM ASTA CARE OF TOLUCA \$30,097										5
6	CRAIG FRANK			10.00		LIST	ATTACHED	SALARY	18,314	17-7	6
7	TOTAL ALLOWABLE SALARY FROM ASTA HEALTHCARE \$165,000										7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$38,397							SALARY	38,397	17-1	8
9	DAVID MEISELMAN-TOTAL SALARY RECEIVED FROM ASTA H			10.00		LIST	ATTACHED	SALARY	17,089	17-7	9
10	SALARY RECEIVED FROM ASTA CARE OF ELGIN \$30,159										10
11	ALIZA FRANK - TOTAL SALARY RECEIVED FROM					LIST	ATTACHED	SALARY	3,820	21-7	11
12	ASTA HEALTHCARE \$34,417										12
13								TOTAL	\$ 114,248		13

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

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

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY

# 0045823

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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

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

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

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	5	UTILITIES	PATIENT DAYS	186,106	6	\$ 773	20,657	\$ 86	1
2	6	MAINTENANCE	PATIENT DAYS	186,106	6	2,228	20,657	247	2
3	10	NURSING	PATIENT DAYS	186,106	6	3,360	20,657	373	3
4	17	OFFICER'S SALARY -MG	PATIENT DAYS	186,106	6	165,000	20,657	18,314	4
5	17	OFFICER'S SALARY - SETH	PATIENT DAYS	186,106	6	165,000	20,657	18,314	5
6	17	ADMIN. SALARY -CF	PATIENT DAYS	186,106	6	165,000	20,657	18,314	6
7	17	ADMIN. SALARY - DM	PATIENT DAYS	186,106	6	153,958	20,657	17,089	7
8	17	ADMIN. SALARY	PATIENT DAYS	186,106	6	273,426	20,657	30,349	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	186,106	6	9,677	20,657	1,074	9
10	20	LICENSES & PERMITS	PATIENT DAYS	186,106	6	5,535	20,657	614	10
11	21	OFFICE EXPENSE	PATIENT DAYS	186,106	6	74,457	20,657	8,264	11
12	24	SEMINARS	PATIENT DAYS	186,106	6	3,319	20,657	368	12
13	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	186,106	6	34,613	20,657	3,842	13
14	26	INSURANCE GEN / WC	PATIENT DAYS	186,106	6	11,622	20,657	1,290	14
15	27	PAYR. TAXES & GRP INS	PATIENT DAYS	186,106	6	59,344	20,657	6,587	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	186,106	6	3,205	20,657	356	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,130,517	\$ 960,161	\$ 125,481	25

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY

# 0045823

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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

1	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	34	RENT	DIRECT	1	1	\$ 300,500	\$ 1	\$ 300,500	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	TOTALS					\$ 300,500	\$	\$ 300,500	25



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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.	\$	<b>29,440</b>	<b>1</b>
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.)	\$	<b>29,792</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>352</b>	<b>3</b>
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>29,792</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>30,144</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002		<b>8</b>
	2003		<b>9</b>
	2004	<b>31,348</b>	<b>10</b>
	2005	<b>30,272</b>	<b>11</b>
	2006	<b>29,792</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.**

**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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME ASTA CARE CENTER-FORD COUNTY COUNTY FORD

FACILITY IDPH LICENSE NUMBER 0045823

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

	(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>11-14-05-300-001</u>	<u>NURSING HOME</u>	\$ <u>29,792.42</u>	\$ <u>29,792.42</u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>29,792.42</u>	\$ <u>29,792.42</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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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: 33,800 B. General Construction Type: Exterior BRICK/WOOD Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (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: 69,000 2. Number of Years Over Which it is Being Amortized: 8

3. Current Period Amortization: 8,625 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

**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	69			\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	NURSE STATION		2002	10,000	364	27.5	364		1,956	9
10	ROOF		2002	28,434	1,034	27.5	1,034		5,558	10
11	NURSE STATION		2002	10,000	363	27.5	363		1,951	11
12	ROOF		2004	31,800	1,156	27.5	1,156		4,576	12
13	ELECTRICAL WORK		2005	3,959	144	27.5	144		366	13
14	SECURITY SYSTEM		2005	52,942	1,925	27.5	1,925		4,572	14
15	ASPHALT SIDEWALK		2005	2,200	147	15	147		349	15
16	10 TON PKG UNIT		2006	8,500	309	27.5	309		399	16
17	EMERGENCY SWITCH PANEL		2006	1,828	66	27.5	66		85	17
18	TILING		2006	1,091	40	27.5	40		52	18
19	WATER HEATER		2007	8,943	230	27.5	230		230	19
20	WATER MAIN WORK		2007	6,857	57	15	57		57	20
21	FLOORING		2007	11,440	2,288	5	1,144	(1,144)	1,144	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

\*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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 177,994	\$ 8,123		\$ 6,979	\$ (1,144)	\$ 21,295	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	\$ 29,623	\$ 5,133	\$ 2,662	\$ (2,471)	10 YRS	\$ 8,732	71
72	Current Year Purchases	5,648	1,130	282	(848)	10 YRS	282	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 35,271	\$ 6,263	\$ 2,944	\$ (3,319)		\$ 9,014	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2001 FORD VAN	2005	\$ 6,189	\$ 3,714	\$ 1,629	\$ (2,085)	5 YEARS	\$ 4,887	76
77										77
78										78
79										79
80	TOTALS			\$ 6,189	\$ 3,714	\$ 1,629	\$ (2,085)		\$ 4,887	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)	\$ 219,454	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,100	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,552	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,548)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 35,196	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: \_\_\_\_\_

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:		69		\$ 132,000			3
4	Additions							4
5								5
6								6
7	TOTAL		69		\$ 132,000			7

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

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

9. Option to Buy:  YES  NO Terms: PURCHASE PRICE \$2,415,000 \*

**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: \$ 8,415 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

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. /2008 \$ 132,000

13. /2009 \$ 132,000

14. /2010 \$ 132,000

\* 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.

**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>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 53,744	\$		\$ 53,744	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			67,712			67,712	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			155,458			155,458	4
5	Physician Care	39-3	visits			566			566	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				90,478		90,478	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	radiology,lab,inhalation,outside svcs Other (specify): <u>supplies, rental</u>	39-8 39-8				16,169	3,509		<u>16,169</u> 3,509	13
14	<b>TOTAL</b>			\$		\$ 293,649	\$ 93,987		\$ 387,636	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 &amp; ID Number ASTA CARE CENTER-FORD COUNTY

# 0045823

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 5,970	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	687,474		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,786		6
7	Other Prepaid Expenses	57,833		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 799,063	\$	10
	<b>B. Long-Term Assets</b>			
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	166,554		15
16	Equipment, at Historical Cost	62,999		16
17	Accumulated Depreciation (book methods)	(56,631)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	69,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(47,438)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <b>SECURITY DEPOSIT</b>	431		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 194,915	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 993,978	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 410,712	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,390,927		29
30	Accrued Salaries Payable	70,317		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,685		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,792		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,913,433	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	110,856		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 110,856	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,024,289	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,030,311)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 993,978	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(880,873)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>1</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(880,872)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(149,439)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(149,439)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,030,311)</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,705,951	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,705,951	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	239,801	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 239,801	8
	<b>C. Other Operating Revenue</b>		
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	38	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 38	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>PRIOR YEAR EXPENSE</b>	35,465	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 35,465	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,981,255	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	644,196	31
32	Health Care	1,117,206	32
33	General Administration	698,069	33
	<b>B. Capital Expense</b>		
34	Ownership	245,809	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	387,636	35
36	Provider Participation Fee	37,778	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,130,694	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(149,439)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (149,439)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number ASTA CARE CENTER-FORD COUNTY

# 0045823

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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	2,934	3,041	\$ 73,649	\$ 24.22	1
2	Assistant Director of Nursing	912	1,024	25,284	24.69	2
3	Registered Nurses	10,438	11,567	243,895	21.09	3
4	Licensed Practical Nurses	6,854	7,371	142,578	19.34	4
5	CNAs & Orderlies	41,946	44,689	411,323	9.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,036	2,204	27,754	12.59	9
10	Activity Assistants	1,804	2,184	17,771	8.14	10
11	Social Service Workers	1,273	1,503	13,569	9.03	11
12	Dietician					12
13	Food Service Supervisor	2,102	2,296	35,899	15.64	13
14	Head Cook	6,482	7,050	65,245	9.25	14
15	Cook Helpers/Assistants	10,447	11,579	86,520	7.47	15
16	Dishwashers					16
17	Maintenance Workers	2,013	2,253	34,177	15.17	17
18	Housekeepers	14,621	15,758	129,496	8.22	18
19	Laundry	661	682	4,872	7.14	19
20	Administrator	4,030	4,175	92,847	22.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,102	2,263	37,885	16.74	23
24	Clerical	3,452	3,787	47,733	12.60	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,107	123,426	\$ 1,490,497 *	\$ 12.08	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 5,060	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,540	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	1,776	11-3	44
45	Social Service Consultant	E	864	12-3	45
46	Other(specify) <u>Physician Conslt</u>	S	4,700	10-3	46
47	<u>Psycho Social Consultant</u>		2,208	10-3	47
48	<u>Psychiatric Consultant</u>		9,500	10-3	48
49	TOTAL (lines 35 - 48)		\$ 25,648		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	488	\$ 14,648	10-3	50
51	Licensed Practical Nurses	888	22,763	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	1,376	\$ 37,411		53





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL HEALTHCARE ASSOC \$3491
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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. \$ 25,000 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. \$ 37,778  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (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