

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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>0042283</u></p> <p>Facility Name: <u>ASTA CARE CENTER OF BLOOMINGTON</u></p> <p>Address: <u>1509 NORTH CALHOUN STREET</u> <u>BLOOMINGTON</u> <u>61701</u> Number City Zip Code</p> <p>County: <u>MCLEAN</u></p> <p>Telephone Number: <u>(847) 742-8822</u> Fax # <u>(847) 742-9013</u></p> <p>HFS ID Number: <u>36-1357503</u></p> <p>Date of Initial License for Current Owners: <u>09/01/96</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>	<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>01/01/2008</u> to <u>12/31/2008</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">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MICHAEL GILLMAN</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>MICHAEL GILLMAN</u>			(Title) <u>MEMBER</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
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<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>	<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>																																									

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON

0042283 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	117	Skilled (SNF)	117	42,822	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	117	TOTALS	117	42,822	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	846		2,996	3,842	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	21,954	3,596	1,017	26,567	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,800	3,596	4,013	30,409	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.01%

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 09/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/96 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 24 and days of care provided 2,588

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	260,878	25,275	10,849	297,002		297,002		297,002		1
2	Food Purchase		208,068		208,068		208,068	(1,834)	206,234		2
3	Housekeeping	184,543	30,957		215,500		215,500		215,500		3
4	Laundry	60,119	11,237		71,356		71,356		71,356		4
5	Heat and Other Utilities			168,697	168,697		168,697		168,697		5
6	Maintenance	66,509	36,096	43,976	146,581		146,581	747	147,328		6
7	Other (specify):*			23,015	23,015		23,015		23,015		7
8	TOTAL General Services	572,049	311,633	246,537	1,130,219		1,130,219	(1,087)	1,129,132		8
	B. Health Care and Programs										
9	Medical Director			12,204	12,204		12,204		12,204		9
10	Nursing and Medical Records	1,160,189	128,677	18,632	1,307,498		1,307,498	7,002	1,314,500		10
10a	Therapy	55,484	265	322	56,071		56,071		56,071		10a
11	Activities	267,877	8,625		276,502		276,502		276,502		11
12	Social Services	49,918			49,918		49,918		49,918		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,533,468	137,567	31,158	1,702,193		1,702,193	7,002	1,709,195		16
	C. General Administration										
17	Administrative	41,192			41,192		41,192	118,176	159,368		17
18	Directors Fees										18
19	Professional Services			79,159	79,159		79,159	1,717	80,876		19
20	Dues, Fees, Subscriptions & Promotions			37,979	37,979		37,979	(9,924)	28,055		20
21	Clerical & General Office Expenses	165,635	31,911	73,320	270,866		270,866	(27,201)	243,665		21
22	Employee Benefits & Payroll Taxes			297,017	297,017		297,017		297,017		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,503	1,503		1,503	575	2,078		24
25	Other Admin. Staff Transportation			3,160	3,160		3,160	5,737	8,897		25
26	Insurance-Prop.Liab.Malpractice			45,329	45,329		45,329	1,799	47,128		26
27	Other (specify):*			79,944	79,944		79,944	(71,452)	8,492		27
28	TOTAL General Administration	206,827	31,911	617,411	856,149		856,149	19,427	875,576		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,312,344	481,111	895,106	3,688,561		3,688,561	25,342	3,713,903		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	7,947
	REPAIRS & MAINTENANCE	2,902
		0
		10,849
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	27,719
	ELECTRICITY	95,798
	WATER	34,189
	CABLE TV - LOBBY	10,991
		0
		168,697
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,565
	PAINTING & DECORATING	1,191
	BUILDING REPAIRS	3,067
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	28,240
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,002
	FIRE SERVICE	2,911
		0
		0
		0
		0
		43,976
7	OTHER	
	SCAVENGER	23,015
	SECURITY SERVICE	0
		0
		0
		23,015
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,204
		12,204

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	12,796
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	5,236
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	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
		18,632
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	322
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		322
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
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	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	11,885
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	67,274
		0
		79,159
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,819
	EMPLOYEE WANT ADS XIX F	16,375
	CONTRIBUTIONS VI 20 XIX F	3,600
	DUES & SUBSCRIPTIONS XIX F	6,873
	LICENSES & PERMITS XIX F	2,495
	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	517
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	700
	PATIENT BACKGROUND CHECKS XIX F	600
		37,979
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,124
	EQUIPMENT REPAIR & MAINTENANCE	2,469
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	33,004
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	24,340
	MESSENGER SERVICE	543
	OUTSIDE BOOKKEEPING SERVICE	7,840
		73,320

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	174,932
	UNEMPLOYMENT COMPENSATION XIX D	25,927
	WORKERS COMPENSATION INSURANC XIX D	77,262
	HOSPITALIZATION INSURANCE XIX D	16,228
	EMPLOYEE BENEFITS - OTHER XIX D	990
	EMPLOYEE PHYSICAL EXAMS XIX D	1,678
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		297,017
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,503
	TRAVEL XIX G	0
		1,503
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,160
		3,160
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	45,329
		45,329
27	OTHER	
	BAD DEBTS VI 24	79,944
		79,944

GRAND TOTAL COLUMN 3 OTHER

895,106

**ASTA CARE CENTER OF BLOOMINGTON
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	208,068
LESS SALES TAX	<u>(1,834)</u>
NET FOOD	206,234

TOTAL PATIENT CENSUS	30,409
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	91,227

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	91,227
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	91,227

NET FOOD	206,234
DIVIDE TOTAL MEALS/YEAR	<u>91,227</u>

COST PER MEAL	2.26
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number

ASTA CARE CENTER OF BLOOMINGTON

#0042283

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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			23,039	23,039		23,039	8,931	31,970			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,855	33,855		33,855	(4,883)	28,972			32
33	Real Estate Taxes			49,633	49,633		49,633		49,633			33
34	Rent-Facility & Grounds			538,740	538,740		538,740		538,740			34
35	Rent-Equipment & Vehicles			21,281	21,281		21,281	498	21,779			35
36	Other (specify):*											36
37	TOTAL Ownership			666,548	666,548		666,548	4,546	671,094			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		120,585	393,750	514,335		514,335		514,335			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,233	64,233		64,233		64,233			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		120,585	457,983	578,568		578,568		578,568			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,312,344	601,696	2,019,637	4,933,677		4,933,677	29,888	4,963,565			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	
	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	8,931	30		9
10	Interest and Other Investment Income	(73)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,834)	2		13
14	Non-Care Related Interest	(4,810)	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	(33,004)	21		18
19	Entertainment		20		19
20	Contributions	(4,117)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(79,944)	27		24
25	Fund Raising, Advertising and Promotional	(6,819)	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	(8,548)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,218)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	160,106		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 160,106		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 29,888		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

ID# 0042283

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3	MARKETING SALARY	(7,600)	21	3
4	MARKETING TRAVEL	(948)	25	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	(8,548)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON# 0042283

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(1,834)	0	0	0	0	0	0	0	0	0	0	(1,834)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	747	0	0	0	0	0	0	0	0	0	747	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,834)	747	0	(1,087)	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	7,002	0	0	0	0	0	0	0	0	0	7,002	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	7,002	0	7,002	16								
	C. General Administration													
17	Administrative	0	118,176	0	0	0	0	0	0	0	0	0	118,176	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,717	0	0	0	0	0	0	0	0	0	1,717	19
20	Fees, Subscriptions & Promotions	(10,936)	1,012	0	0	0	0	0	0	0	0	0	(9,924)	20
21	Clerical & General Office Expenses	(40,604)	13,403	0	0	0	0	0	0	0	0	0	(27,201)	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	575	0	0	0	0	0	0	0	0	0	575	24
25	Other Admin. Staff Transportation	(948)	6,685	0	0	0	0	0	0	0	0	0	5,737	25
26	Insurance-Prop.Liab.Malpractice	0	1,799	0	0	0	0	0	0	0	0	0	1,799	26
27	Other (specify):*	(79,944)	8,492	0	0	0	0	0	0	0	0	0	(71,452)	27
28	TOTAL General Administration	(132,432)	151,859	0	19,427	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(134,266)	159,608	0	25,342	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,931	0	0	0	0	0	0	0	0	0	0	8,931	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,883)	0	0	0	0	0	0	0	0	0	0	(4,883)	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	498	0	0	0	0	0	0	0	0	0	498	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	4,048	498	0	4,546	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(130,218)	160,106	0	29,888	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		
				COMPANY, INC.	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	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		ASTA HEALTHCARE COMPANY, INC.		\$		1
2	V	6				747	747	2
3	V	10				7,002	7,002	3
4	V	17				118,176	118,176	4
5	V	19				1,717	1,717	5
6	V	20				1,012	1,012	6
7	V	21				13,403	13,403	7
8	V	24				575	575	8
9	V	25				6,685	6,685	9
10	V	26				1,799	1,799	10
11	V	27				8,492	8,492	11
12	V	35				498	498	12
13	V							13
14	Total		\$			\$ 160,106	\$ * 160,106	14

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

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTC # 0042283 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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			40.00	LIST ATTACHED	LIST	ATTACHED	SALARY	\$ 32,080	17-7	1
2											2
3	SETH GILLMAN			7.50	LIST ATTACHED	LIST	ATTACHED	SALARY	20,197	17-7	3
4	PROFESSIONAL FEE FOR WOUND BILLING \$3,964							PROF FEES	3,964	19-3	4
5	SALARY FROM ASTA CARE OF TOLUCA \$31,317										5
6											6
7	CRAIG FRANK				LIST ATTACHED	LIST	ATTACHED	SALARY	24,883	17-7	7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$43,572										8
9											9
10	DAVID MEISELMAN				LIST ATTACHED	LIST	ATTACHED	SALARY	1,993	17-7	10
11	SALARY FROM ASTA CARE OF ELGIN \$233,408										11
12	ALIZA FRANK			7.50	LIST ATTACHED	LIST	ATTACHED	SALARY	5,361	21-7	12
13								TOTAL	\$ 88,478		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 BLOOMINGTON

0042283

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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	6	MAINTENANCE	PATIENT DAYS	184,841	6	\$ 4,539	\$ 30,409	\$ 747	1	
2	10	NURSING	PATIENT DAYS	184,841	6	42,560	42,560	30,409	7,002	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	184,841	6	195,000	195,000	30,409	32,080	3
4	17	OFFICER'S SALARY - SETH	PATIENT DAYS	184,841	6	122,770	122,770	30,409	20,197	4
5	17	ADMIN. SALARY -CF	PATIENT DAYS	184,841	6	151,251	151,251	30,409	24,883	5
6	17	ADMIN. SALARY - DM	PATIENT DAYS	184,841	6	12,117	12,117	30,409	1,993	6
7	17	ADMIN. SALARY	PATIENT DAYS	184,841	6	184,098	184,098	30,409	30,287	7
8	17	OUTSIDE CLERICAL	PATIENT DAYS	184,841	6	53,100		30,409	8,736	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	184,841	6	10,435		30,409	1,717	9
10	20	LICENSES & PERMITS	PATIENT DAYS	184,841	6	6,154		30,409	1,012	10
11	21	OFFICE EXPENSE	PATIENT DAYS	184,841	6	48,883	5,629	30,409	8,042	11
12	21	CLERICAL SALARY-AF	PATIENT DAYS	184,841	6	32,584	32,584	30,409	5,361	12
13	24	SEMINARS	PATIENT DAYS	184,841	6	3,497		30,409	575	13
14	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	184,841	6	40,634		30,409	6,685	14
15	26	INSURANCE GEN / WC	PATIENT DAYS	184,841	6	10,938		30,409	1,799	15
16	27	PAYR. TAXES & GRP INS	PATIENT DAYS	184,841	6	51,620		30,409	8,492	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	184,841	6	3,029		30,409	498	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 973,209	\$ 746,009		\$ 160,106	25

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTO

0042283

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6		X	BLOOMINGTON PROP						22,448	6										
7		X	INSURANCE POLICIES						2,074	7										
8	MEMBER LOANS	X	WORKING CAPITAL						4,523	8										
9	TOTAL Facility Related								29,045	9										
B. Non-Facility Related*																				
10			BED TAX INTEREST						4,810	10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related								4,810	14										
15	TOTALS (line 9+line14)								33,855	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 must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.

\$ **44,982** 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.)

\$ **47,308** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **2,325** 3

4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **47,308** 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.

\$ **49,633** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	40,362	8
	2004	42,477	9
	2005	43,745	10
	2006	44,982	11
	2007	47,308	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	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.**

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 BLOOMINGTON# 0042283

Report Period Beginning:

01/01/2008 Ending: 12/31/2008**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		ROOF & DOORS	1997		8,588	220	39	220		2,466	9
10		FIRE ALARM CONTROL PANEL	1998		2,880	74	39	74		780	10
11		CHECK VALVES INSTALLATION	1998		3,192	82	39	82		864	11
12		WATER HEATER	1998		5,965	153	39	153		1,613	12
13		ROOF & DOORS	1999		14,774	537	27.5	537		5,124	13
14		GARAGE	1999		9,320	339	27.5	339		3,235	14
15		FENCE	1999		3,510	234	15	234		2,233	15
16		A/C ROOF UNIT COMPRESSOR	1999		2,314	84	27.5	84		802	16
17		VALVES	2000		1,232	44	27.5	44		376	17
18		BUILD IN CHART RACKS	2000		1,980	72	27.5	72		615	18
19		ROOF & DOORS	2000		13,310	484	27.5	484		4,138	19
20		ELECTRICAL WORK	2000		1,600	58	27.5	58		496	20
21		DISPOSAL	2000		1,820	66	27.5	66		564	21
22		ELECTRICAL	2000		1,774	64	27.5	64		547	22
23		WATER LINE	2000		3,100	114	27.5	114		973	23
24		CURTAINS	2000		1,679		10	168	168	1,434	24
25		CARPETING	2000		4,599		10	460	460	3,910	25
26		ELECTRICAL	2001		11,927	434	27.5	434		3,273	26
27		ROOF TOP UNIT	2001		6,886	250	27.5	250		1,886	27
28		FLASHING ON ROOF	2001		5,930	215	27.5	215		1,622	28
29		FENCE	2001		1,722	63	27.5	63		475	29
30		BATHROOM	2001		3,370	123	27.5	123		927	30
31		CARPETING	2001		6,671		10	667	667	5,003	31
32		TILING	2001		8,363		10	836	836	6,270	32
33		PLUMBING	2002		10,533	383	27.5	383		2,506	33
34		TILING	2002		6,761	246	27.5	246		1,609	34
35		ROOF TOP UNIT	2002		6,775	246	27.5	246		1,609	35
36		ROOF TOP HEAT/COOL UNIT	2003		6,950	253	27.5	253		1,402	36

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

See Page 12A, Line 70 for total

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

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	DOOR ALARM SYSTEM	2004	\$ 7,077	\$ 258	27.5	\$ 258		\$ 1,043	37
38	PTAC HEAT PUMP/COOL	2004	1,440	52	27.5	52		210	38
39	SIDEWALK	2005	6,119	408	15	221	(187)	884	39
40	DOOR ALARM	2005	4,523	164	27.5	164		554	40
41	NEW VALVE	2005	4,719	171	27.5	171		577	41
42	ELECTRICAL WORK	2005	1,661	61	27.5	61		206	42
43	CARPETING	2006	9,844	1,890	10	984	(906)	2,460	43
44	WATER HEATER	2006	9,407	342	27.5	342		840	44
45	ROOFTOP HEAT/COOL UNIT	2006	9,114	331	27.5	331		814	45
46	SIDEWALK & CONCRETE PAVING	2006	7,695	513	15	513		1,304	46
47	NEW WATER SYSTEM	2007	22,144	805	27.5	805		1,107	47
48	PLUMBING REMODELING FOR DIALYSIS AREA	2007	12,483	454	27.5	454		625	48
49	WIRING FOR DIALYSIS ROOM	2007	2,656	97	27.5	97		133	49
50	SIDEWALKS	2007	5,603	374	15	374		545	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)		\$ 262,010	\$ 10,758		\$ 11,796	\$ 1,038	\$ 68,054	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	\$ 208,131	\$ 12,281	\$ 20,174	\$ 7,893	10 yrs	\$ 125,160	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	40,569					40,569	73
74								74
75	TOTALS	\$ 248,700	\$ 12,281	\$ 20,174	\$ 7,893		\$ 165,729	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	ADMIN, ACTIVITY	1995 FORD	1997	\$ 33,841	\$	\$	\$		\$ 33,841	76
77										77
78										78
79										79
80	TOTALS			\$ 33,841	\$	\$	\$		\$ 33,841	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)	\$ 544,551	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,039	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,970	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,931	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 267,624	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:		117		\$ 538,740			3
4	Additions							4
5								5
6								6
7	TOTAL		117		\$ 538,740			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: _____*

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: \$ 21,281 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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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	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	\$		\$ 117,411	\$		\$ 117,411	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			25,889			25,889	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			215,628			215,628	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				115,491		115,491	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>					34,822	5,094		39,916	13
14	TOTAL			\$		\$ 393,750	\$ 120,585		\$ 514,335	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 BLOOMINGTON

0042283

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,015,555		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,480		6
7	Other Prepaid Expenses	17,117		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>employee loans,adv wage assgn</u>	17,910		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,081,062	\$	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	230,854		15
16	Equipment, at Historical Cost	313,697		16
17	Accumulated Depreciation (book methods)	(345,290)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 199,261	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,280,323	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,276,200	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,602,509		29
30	Accrued Salaries Payable	91,322		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,718		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,308		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)	\$ 3,030,057	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	320,856		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 320,856	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,350,913	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,070,590)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,280,323	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,799,603)	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,799,600)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(270,990)	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)	\$ (270,990)	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)	\$ (2,070,590)	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	\$ 4,331,393	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,331,393	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	301,665	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 301,665	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	73	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 73	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER EXPENSE ADJ,	29,556	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,556	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,662,687	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,130,219	31
32	Health Care	1,702,193	32
33	General Administration	856,149	33
	B. Capital Expense		
34	Ownership	666,548	34
	C. Ancillary Expense		
35	Special Cost Centers	514,335	35
36	Provider Participation Fee	64,233	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,933,677	40
41	Income before Income Taxes (line 30 minus line 40)**	(270,990)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (270,990)	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 BLOOMINGTON

0042283

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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	1,576	1,712	\$ 48,667	\$ 28.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,021	7,472	169,648	22.70	3
4	Licensed Practical Nurses	18,283	19,887	451,211	22.69	4
5	CNAs & Orderlies	41,431	43,513	457,338	10.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,721	2,883	55,484	19.25	8
9	Activity Director	2,109	2,377	40,174	16.90	9
10	Activity Assistants	19,617	21,274	227,703	10.70	10
11	Social Service Workers	3,925	4,187	49,918	11.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	12,798	14,174	150,171	10.59	14
15	Cook Helpers/Assistants	11,025	11,634	110,707	9.52	15
16	Dishwashers					16
17	Maintenance Workers	4,253	4,632	66,509	14.36	17
18	Housekeepers	17,081	18,638	184,543	9.90	18
19	Laundry	5,662	6,178	60,119	9.73	19
20	Administrator	1,064	1,242	41,192	33.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,932	10,039	165,635	16.50	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	1,796	2,045	33,325	16.30	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,294	171,887	\$ 2,312,344 *	\$ 13.45	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	\$ 7,947	1-3	35
36	Medical Director	O	12,204	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	600	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		322	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	PSYCHO-SOCIAL		5,236	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,309		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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	
LAURA ARBUCKLE	ADMINISTRATOR	0	\$ 21,420	Workers' Compensation Insurance	\$ 77,262	IDPH License Fee	\$	
PATRICIA GRADY	ADMINISTRATOR	0	19,772	Unemployment Compensation Insurance	25,927	Advertising: Employee Recruitment	16,375	
	OTHER ADMIN		0	FICA Taxes	174,932	Health Care Worker Background Check	700	
				Employee Health Insurance	16,228	(Indicate # of checks performed <u>70</u>)		
				Employee Meals	0	Patient Background Checks	60	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,117	
				EMPLOYEE BENEFITS - OTHER	990	MARKETING/ADV/PROMO	6,819	
				EMPLOYEE PHYSICAL EXAMS	1,678	LICENSES/DUES/SUBSCRIPTIONS	9,368	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	1,012	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(4,117)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(6,819)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 41,192	TOTAL (agree to Schedule V, line 22, col.8)	\$ 297,017	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,055	
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
			\$ 0			\$	Out-of-State Travel	\$
							In-State Travel	0
							Seminar Expense	1,503
							MGMT CO ALLOC	575
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,078
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			79,159					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 79,159					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON

0042283

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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. \$5942
- (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. \$ 18,653 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. \$ 64,233
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