



Facility Name & ID Number ASTA CARE CENTER OF ELGIN

# 0041608 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	<u>52</u>	Skilled (SNF)	<u>52</u>	<u>19,032</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>50</u>	Intermediate (ICF)	<u>50</u>	<u>18,300</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>102</u>	<b>TOTALS</b>	<u>102</u>	<u>37,332</u>	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	<u>2,046</u>	<u>491</u>	<u>5,351</u>	<u>7,888</u>	8
9	SNF/PED					9
10	ICF	<u>22,790</u>	<u>1,570</u>	<u>426</u>	<u>24,786</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	<b>TOTALS</b>	<u>24,836</u>	<u>2,061</u>	<u>5,777</u>	<u>32,674</u>	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.52%**

**D. How many bed-hold days during this year were paid by the Department?**  
0 (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients.**  
(E.g., day care, "meals on wheels", outpatient therapy)  
NONE

**F. Does the facility maintain a daily midnight census?** YES

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**  
YES  NO

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**  
YES  NO

**I. On what date did you start providing long term care at this location?**  
Date started 03/29/96

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 06/29/96 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 24 and days of care provided 4,796

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

**IV. ACCOUNTING BASIS**

ACCRUAL  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 ELGIN # 0041608 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
	<b>A. General Services</b>										
1	Dietary	267,011	34,192	11,568	312,771		312,771		312,771		1
2	Food Purchase		193,153		193,153		193,153	(2,222)	190,931		2
3	Housekeeping	258,481	28,625		287,106		287,106		287,106		3
4	Laundry	63,269	24,336		87,605		87,605		87,605		4
5	Heat and Other Utilities			123,100	123,100		123,100		123,100		5
6	Maintenance	48,915	26,764	43,993	119,672		119,672	1,913	121,585		6
7	Other (specify):*			33,976	33,976		33,976		33,976		7
8	<b>TOTAL General Services</b>	637,676	307,070	212,637	1,157,383		1,157,383	(309)	1,157,074		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			14,000	14,000		14,000		14,000		9
10	Nursing and Medical Records	1,343,073	137,599	2,835	1,483,507		1,483,507	7,523	1,491,030		10
10a	Therapy	132,265	2,407	288	134,960		134,960		134,960		10a
11	Activities	109,178	29,255	6,126	144,559		144,559		144,559		11
12	Social Services	75,322		478	75,800		75,800		75,800		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,659,838	169,261	23,727	1,852,826		1,852,826	7,523	1,860,349		16
	<b>C. General Administration</b>										
17	Administrative	233,408		180,000	413,408		413,408	(53,021)	360,387		17
18	Directors Fees										18
19	Professional Services			53,993	53,993		53,993	400	54,393		19
20	Dues, Fees, Subscriptions & Promotions			23,701	23,701		23,701	(9,426)	14,275		20
21	Clerical & General Office Expenses	104,883	26,845	89,732	221,460		221,460	(27,248)	194,212		21
22	Employee Benefits & Payroll Taxes			289,432	289,432		289,432		289,432		22
23	Inservice Training & Education			1,620	1,620		1,620		1,620		23
24	Travel and Seminar							618	618		24
25	Other Admin. Staff Transportation			2,746	2,746		2,746	5,731	8,477		25
26	Insurance-Prop.Liab.Malpractice			76,480	76,480		76,480	1,933	78,413		26
27	Other (specify):*			170,174	170,174		170,174	(161,049)	9,125		27
28	<b>TOTAL General Administration</b>	338,291	26,845	887,878	1,253,014		1,253,014	(242,062)	1,010,952		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,635,805	503,176	1,124,242	4,263,223		4,263,223	(234,848)	4,028,375		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	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	9,134
	REPAIRS & MAINTENANCE	2,434
		0
		11,568
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	43,045
	ELECTRICITY	44,997
	WATER	34,220
	CABLE TV - LOBBY	838
		0
		123,100
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	6,911
	PAINTING & DECORATING	0
	BUILDING REPAIRS	7,593
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	17,165
	ELEVATOR MAINTENANCE & REPAIR	1,812
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,375
	FIRE SERVICE	4,604
	PAINTING & DECORATING	2,533
		0
		0
		0
		43,993
7	<b>OTHER</b>	
	SCAVENGER	33,976
	SECURITY SERVICE	0
		0
		0
		33,976
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	14,000
		14,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	486
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,749
	PHARMACY CONSULTANT XVIII B 39-2	600
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		2,835
10a	<b>THERAPY</b>	
	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 CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	288
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		288
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	6,126
		0
		6,126
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	478
	SOCIAL WORKER XVIII B 45-2	0
		0
		478
13	<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	180,000
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	16,184
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	37,809
		0
		53,993
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,424
	EMPLOYEE WANT ADS XIX F	3,600
	CONTRIBUTIONS VI 20 XIX F	3,600
	DUES & SUBSCRIPTIONS XIX F	6,381
	LICENSES & PERMITS XIX F	1,876
	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	490
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	730
	PATIENT BACKGROUND CHECKS XIX F	600
		23,701
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	6,306
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	9,306
	PENALTIES / OVERDRAFT CHARGES VI 18	36,776
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	34,611
	MESSENGER SERVICE	2,733
		0
		89,732

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	193,498
	UNEMPLOYMENT COMPENSATION XIX D	20,339
	WORKERS COMPENSATION INSURANC XIX D	55,630
	HOSPITALIZATION INSURANCE XIX D	18,753
	EMPLOYEE BENEFITS - OTHER XIX D	597
	EMPLOYEE PHYSICAL EXAMS XIX D	615
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		289,432
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	1,620
		1,620
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	2,746
		2,746
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	76,480
		76,480
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	170,174
		170,174

GRAND TOTAL COLUMN 3 OTHER

1,124,242

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

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

TOTAL FOOD PURCHASE	193,153
LESS SALES TAX	<u>(2,222)</u>
NET FOOD	190,931

TOTAL PATIENT CENSUS	32,674
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	98,022

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

PATIENT MEALS	98,022
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	98,022

NET FOOD	190,931
DIVIDE TOTAL MEALS/YEAR	<u>98,022</u>

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

=====

Facility Name &amp; ID Number

ASTA CARE CENTER OF ELGIN

#0041608

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	
	<b>D. Ownership</b>											
30	Depreciation			35,720	35,720		35,720	(5,807)	29,913			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,133	69,133		69,133	(5,664)	63,469			32
33	Real Estate Taxes			83,459	83,459		83,459		83,459			33
34	Rent-Facility & Grounds			464,280	464,280		464,280		464,280			34
35	Rent-Equipment & Vehicles			21,636	21,636		21,636	535	22,171			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			674,228	674,228		674,228	(10,936)	663,292			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		208,053	364,296	572,349		572,349		572,349			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,998	55,998		55,998		55,998			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		208,053	420,294	628,347		628,347		628,347			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,635,805	711,229	2,218,764	5,565,798		5,565,798	(245,784)	5,320,014			45

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



## ASTA CARE CENTER OF ELGIN

ID# 0041608

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,111	6	1
2	MARKETING SALARY	(4,873)	21	2
3	MARKETING TRAVEL	(1,452)	25	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,214)		49

## STATE OF ILLINOIS

Summary A

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

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	(2,222)	0	0	0	0	0	0	0	0	0	0	(2,222)	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	1,111	802	0	0	0	0	0	0	0	0	0	1,913	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,111)</b>	<b>802</b>	<b>0</b>	<b>(309)</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	7,523	0	0	0	0	0	0	0	0	0	7,523	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>7,523</b>	<b>0</b>	<b>7,523</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	(53,021)	0	0	0	0	0	0	0	0	0	(53,021)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,445)	1,845	0	0	0	0	0	0	0	0	0	400	19
20	Fees, Subscriptions & Promotions	(10,514)	1,088	0	0	0	0	0	0	0	0	0	(9,426)	20
21	Clerical & General Office Expenses	(41,649)	14,401	0	0	0	0	0	0	0	0	0	(27,248)	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	618	0	0	0	0	0	0	0	0	0	618	24
25	Other Admin. Staff Transportation	(1,452)	7,183	0	0	0	0	0	0	0	0	0	5,731	25
26	Insurance-Prop.Liab.Malpractice	0	1,933	0	0	0	0	0	0	0	0	0	1,933	26
27	Other (specify):*	(170,174)	9,125	0	0	0	0	0	0	0	0	0	(161,049)	27
28	<b>TOTAL General Administration</b>	<b>(225,234)</b>	<b>(16,828)</b>	<b>0</b>	<b>(242,062)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(226,345)</b>	<b>(8,503)</b>	<b>0</b>	<b>(234,848)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

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

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 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	(5,807)	0	0	0	0	0	0	0	0	0	0	(5,807)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,664)	0	0	0	0	0	0	0	0	0	0	(5,664)	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	535	0	0	0	0	0	0	0	0	0	535	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(11,471)</b>	<b>535</b>	<b>0</b>	<b>(10,936)</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>(237,816)</b>	<b>(7,968)</b>	<b>0</b>	<b>(245,784)</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 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 FEES	\$ 180,000	ASTA HEALTHCARE COMPANY, INC.		\$	(180,000)	1
2	V	6 MAINTENANCE				802	802	2
3	V	10 NURSING				7,523	7,523	3
4	V	17 ADMINISTRATIVE				126,979	126,979	4
5	V	19 PROFESSIONAL FEES				1,845	1,845	5
6	V	20 LICENSES & PERMITS				1,088	1,088	6
7	V	21 OFFICE EXPENSE				14,401	14,401	7
8	V	24 SEMINARS				618	618	8
9	V	25 STAFF TRANS/ TRAVEL				7,183	7,183	9
10	V	26 INSURANCE GEN / WC				1,933	1,933	10
11	V	27 PAYR. TAXES & GRP INS				9,125	9,125	11
12	V	35 EQUIPMENT RENTAL				535	535	12
13	V							13
14	Total		\$ 180,000			\$ 172,032	\$ * (7,968)	14

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2008 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	\$ 34,470	17-7	1
2											2
3	SETH GILLMAN			7.50	LIST ATTACHED	LIST	ATTACHED	SALARY	21,702	17-7	3
4	PROFESSIONAL FEE FOR WOUND BILLING (BLOOMINGTON) \$3,964										4
5	SALARY FROM ASTA CARE OF TOLUCA \$31,317										5
6											6
7	CRAIG FRANK				LIST ATTACHED	LIST	ATTACHED	SALARY	26,736	17-7	7
8	SALARY FROM ASTA CARE OF FORD COUNTY \$43,572										8
9											9
10	DAVID MEISELMAN				LIST ATTACHED	LIST	ATTACHED	SALARY	2,142	17-7	10
11	SALARY FROM ASTA CARE OF ELGIN \$233,408							SALARY	233,408	17-1	11
12	ALIZA FRANK			7.50	LIST ATTACHED	LIST	ATTACHED	SALARY	5,760	21-7	12
13								TOTAL	\$ 324,218		13

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

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

# 0041608

Report Period Beginning:

01/01/2008

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 COMPANY  
 Street Address 134 NORTH MCLEAN BLVD  
 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	\$ 32,674	\$ 802	1	
2	10	NURSING	PATIENT DAYS	184,841	6	42,560	42,560	32,674	7,523	2
3	17	OFFICER'S SALARY -MG	PATIENT DAYS	184,841	6	195,000	195,000	32,674	34,470	3
4	17	OFFICER'S SALARY - SETH	PATIENT DAYS	184,841	6	122,770	122,770	32,674	21,702	4
5	17	ADMIN. SALARY -CF	PATIENT DAYS	184,841	6	151,251	151,251	32,674	26,736	5
6	17	ADMIN. SALARY - DM	PATIENT DAYS	184,841	6	12,117	12,117	32,674	2,142	6
7	17	ADMIN. SALARY	PATIENT DAYS	184,841	6	184,098	184,098	32,674	32,543	7
8	17	OUTSIDE CLERICAL	PATIENT DAYS	184,841	6	53,100		32,674	9,386	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	184,841	6	10,435		32,674	1,845	9
10	20	LICENSES & PERMITS	PATIENT DAYS	184,841	6	6,154		32,674	1,088	10
11	21	OFFICE EXPENSE	PATIENT DAYS	184,841	6	48,883	5,629	32,674	8,641	11
12	21	CLERICAL SALARY-AF	PATIENT DAYS	184,841	6	32,584	32,584	32,674	5,760	12
13	24	SEMINARS	PATIENT DAYS	184,841	6	3,497		32,674	618	13
14	25	STAFF TRANS/ TRAVEL	PATIENT DAYS	184,841	6	40,634		32,674	7,183	14
15	26	INSURANCE GEN / WC	PATIENT DAYS	184,841	6	10,938		32,674	1,933	15
16	27	PAYR. TAXES & GRP INS	PATIENT DAYS	184,841	6	51,620		32,674	9,125	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	184,841	6	3,029		32,674	535	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 973,209	\$ 746,009		\$ 172,032	25

Facility Name & ID Number

ASTA CARE CENTER OF ELGIN

# 0041608

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	Name of Lender	2		3	4	5	6		8	9	10						
		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1							\$	\$			\$						
2																	
3																	
4																	
5	INSURANCE POLICIES										3,282						
<b>Working Capital</b>																	
6	First Chicago Bank & Trust		x	WORKING CAPITAL	INT	REVOLV		595,475	REVOLV	0.0375	36,383						
7	Harris Bank - Member			WORKING CAPITAL							4,523						
8	Elgin Nursing Home Prop										19,345						
9	TOTAL Facility Related						\$	595,475			\$ 63,533						
<b>B. Non-Facility Related*</b>																	
10	IRS, IDR, ETC		X	LATE FEES													
11	BED TAX										5,600						
12																	
13																	
14	TOTAL Non-Facility Related						\$				\$ 5,600						
15	TOTALS (line 9+line14)						\$	595,475			\$ 69,133						

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.		\$	<b>84,432</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>83,945</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(487)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>83,946</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>83,459</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2003</b>	<b>71,235</b>	<b>8</b>
	<b>2004</b>	<b>75,184</b>	<b>9</b>
	<b>2005</b>	<b>80,254</b>	<b>10</b>
	<b>2006</b>	<b>84,432</b>	<b>11</b>
	<b>2007</b>	<b>83,945</b>	<b>12</b>

**FOR BHF USE ONLY**

<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007	\$	<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>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME ASTA CARE CENTER OF ELGIN COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0041608

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-15-176-011</u>	<u>NURSING HOME</u>	\$ <u>76,684.76</u>	\$ <u>76,684.76</u>
2. <u>06-15-176-043</u>	<u>NURSING HOME</u>	\$ <u>974.40</u>	\$ <u>974.40</u>
3. <u>06-15-176-044</u>	<u>NURSING HOME</u>	\$ <u>6,285.48</u>	\$ <u>6,285.48</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>83,944.64</u>	\$ <u>83,944.64</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

# 0041608

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

N/A

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

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

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

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

Report Period Beginning:

01/01/2008 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
	<b>Improvement Type**</b>										
9		FLOOR DRAIN		1997	1,297	33	39	33		381	9
10		INSTALL SHOWER VALVE AND DRAIN		1997	4,142	105	39	105		1,213	10
11		RE KEY DOOR LOCKS		1997	4,085	104	39	104		1,201	11
12		NEW AIR VENTS		1997	616	18	39	18		207	12
13		FIRE ALARM SYSTEM		1997	2,192	56	39	56		646	13
14		AWNINGS		1997	1,020	26	39	26		300	14
15		SEWAGE EJECTOR PUMP		1998	3,961	102	39	102		1,083	15
16		HOT WATER PUMP		1998	5,439	139	39	139		1,419	16
17		AWNINGS		1999	685	25	27.5	25		239	17
18		FLOORING		1999	2,474	90	27.5	90		859	18
19		ELECTRICAL WORK		1999	9,378	341	27.5	341		3,254	19
20		MAGNETIC DOOR LOCKS		1999	2,054	74	27.5	74		706	20
21		FIRE SPRINKLER SYSTEM		1999	3,868	141	27.5	141		1,345	21
22		BOILER		1999	4,890	178	27.5	178		1,698	22
23		NURSE STATION		2000	16,280	592	27.5	592		5,057	23
24		CONDENSING UNIT		2000	4,683	170	27.5	170		1,452	24
25		WATER HEATER		2000	8,731	317	27.5	317		2,708	25
26		POWER VENT FOR WATER HEATER		2000	2,682	98	27.5	98		837	26
27		NEW WALLS		2000	2,000	73	27.5	73		623	27
28		HOT WATER PIPING		2000	4,708	171	27.5	171		1,461	28
29		DRAPERIES		2000	2,303		7			2,303	29
30		EJECTOR PUMP		2001	14,041	511	27.5	511		3,854	30
31		ROOF		2001	6,218	226	27.5	226		1,704	31
32		COMPRESSOR		2001	3,501	127	27.5	127		958	32
33		PRESSURE BACK FLOW PREVENTER		2002	3,870	141	27.5	141		922	33
34		FIRE ALARM SYSTEM		2002	37,625	1,368	27.5	1,368		8,949	34
35		RE KEY LOCKS		2002	1,346	49	27.5	49		321	35
36		PATIENT SECURITY SYSTEM		2002	2,719	99	27.5	99		647	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.

Facility Name &amp; ID Number ASTA CARE CENTER OF ELGIN

# 0041608

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WATER HEATER	2002	\$ 4,864	\$ 177	27.5	\$ 177		\$ 1,158	37
38	NEW PIPE	2002	1,575	57	27.5	57		373	38
39	VINYL FLOORING	2002	17,779		5			17,779	39
40	HANDRAILS,BUMPERS,CORNER	2003	17,903	651	27.5	651		3,608	40
41	SMOKE DAMPERS	2003	1,904	69	27.5	69		382	41
42	DOOR ALARM SYSTEM	2003	3,097	113	27.5	113		626	42
43	SMOKING PORCH	2003	764	28	27.5	28		155	43
44	WALLCOVERINGS & PAINTING	2003	26,197	1,055	5		(1,055)	26,197	44
45	DIALYSIS ROOM	2004	23,267	846	27.5	846		3,842	45
46	VALVE ACTUATOR	2004	3,240	118	27.5	118		477	46
47	HOT WATER HEATER	2004	6,837	248	27.5	248		1,002	47
48	CURTAINS	2005	1,513	174	5	323	149	1,272	48
49	FIRE ALARM SYSTEM	2005	4,026	146	27.5	146		517	49
50	SPRINKLER HEADS	2005	2,530	92	27.5	92		326	50
51	FIRE DOOR	2005	547	20	27.5	20		71	51
52	ASPHALT	2005	6,000	400	15	400		1,417	52
53	ELEVATOR EMERGENCY STOP SWITCH	2006	1,849	67	27.5	67		170	53
54	PARKING LOT	2007	26,200	1,747	15	1,747		2,548	54
55	BOILER	2007	4,245	154	27.5	154		225	55
56	WATER HEATER	2007	6,453	235	27.5	235		342	56
57	NURSE CALL SYSTEM	2007	2,536	92	27.5	92		134	57
58	A/C CONDENSER	2007	5,928	216	27.5	216		315	58
59	5 TON A/C	2007	3,000	109	27.5	109		159	59
60	BLACK TOP AND SEAL THE PARKING LOT	2008	10,700	89	15	89		89	60
61	ROOF	2008	3,800	63	27.5	63		63	61
62	GENERATOR REPAIR	2008	4,578	77	27.5	77		77	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 348,140	\$ 12,417		\$ 11,511	\$ (906)	\$ 109,671	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	\$ 182,319	\$ 11,164	\$ 17,246	\$ 6,082		\$ 108,055	71
72	Current Year Purchases	23,122	12,139	1,156	(10,983)		1,156	72
73	Fully Depreciated Assets	86,865					86,865	73
74								74
75	TOTALS	\$ 292,306	\$ 23,303	\$ 18,402	\$ (4,901)		\$ 196,076	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 640,446	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,720	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,913	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,807)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 305,747	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: ELGIN NURSING HOME PROPERTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>102</u>		\$ <u>464,280</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		102		\$ 464,280			7

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: \$ 16,925 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ <u>4,711</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 4,711	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><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	\$		\$ 73,122	\$		\$ 73,122	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			28,743			28,743	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			216,552			216,552	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				199,700		199,700	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					45,879	8,353		54,232	13
14	<b>TOTAL</b>			\$		\$ 364,296	\$ 208,053		\$ 572,349	14

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

# 0041608

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 195,880	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,013,004		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,530		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	325,344		8
9	Other(specify):	11,151		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,581,909	\$	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	348,140		15
16	Equipment, at Historical Cost	292,306		16
17	Accumulated Depreciation (book methods)	(377,499)		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): <b>UTILITY SECURITY DEP</b>	16,895		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 279,842	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,861,751	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,269,786	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	595,483		29
30	Accrued Salaries Payable	106,221		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,996		31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,946		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 (sum of lines 26 thru 37)</b>	\$ 2,066,432	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44	<b>MEMBER LOANS</b>	730,264		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 730,264	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,796,696	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (934,945)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,861,751	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (949,181)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>ROUNDING</b>	(1)	<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>	\$ (949,182)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	14,237	<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>	\$ 14,237	<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>	\$ (934,945)	<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	\$ 5,328,316	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,328,316	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	251,655	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 251,655	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***	64	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 64	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,580,035	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,157,383	31
32	Health Care	1,852,826	32
33	General Administration	1,253,014	33
	<b>B. Capital Expense</b>		
34	Ownership	674,228	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	572,349	35
36	Provider Participation Fee	55,998	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>	\$ 5,565,798	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	14,237	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 14,237	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number ASTA CARE CENTER OF ELGIN

# 0041608

Report Period Beginning: 01/01/2008

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	1,977	2,051	\$ 87,378	\$ 42.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,732	6,363	213,830	33.61	3
4	Licensed Practical Nurses	14,758	15,890	436,649	27.48	4
5	CNAs & Orderlies	45,996	46,722	562,072	12.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,434	5,766	132,265	22.94	8
9	Activity Director	2,041	2,299	38,515	16.75	9
10	Activity Assistants	7,157	7,995	70,663	8.84	10
11	Social Service Workers	3,889	4,251	75,322	17.72	11
12	Dietician					12
13	Food Service Supervisor	2,043	2,198	52,027	23.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,920	18,757	214,984	11.46	15
16	Dishwashers					16
17	Maintenance Workers	2,041	2,183	48,915	22.41	17
18	Housekeepers	23,546	25,483	258,481	10.14	18
19	Laundry	6,627	6,864	63,269	9.22	19
20	Administrator	2,250	2,255	233,408	103.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,874	4,237	104,883	24.75	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	1,934	2,163	43,144	19.95	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,219	155,477	\$ 2,635,805 *	\$ 16.95	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	\$ 9,134	1-3	35
36	Medical Director	O	14,000	9-3	36
37	Medical Records Consultant	N	1,749	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		288	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	6,126	11-3	44
45	Social Service Consultant	E	478	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,375		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	
<u>DAVID MEISELMAN</u>	<u>ADMINISTRATOR</u>		\$ <u>233,408</u>	<u>Workers' Compensation Insurance</u>	\$ <u>55,630</u>	<u>IDPH License Fee</u>	\$	
	<u>ASST ADMIN</u>		<u>0</u>	<u>Unemployment Compensation Insurance</u>	<u>20,339</u>	<u>Advertising: Employee Recruitment</u>	<u>3,600</u>	
	<u>OTHER ADMIN</u>		<u>0</u>	<u>FICA Taxes</u>	<u>193,498</u>	<u>Health Care Worker Background Check</u>	<u>730</u>	
				<u>Employee Health Insurance</u>	<u>18,753</u>	(Indicate # of checks performed <u>73</u> )		
				<u>Employee Meals</u>	<u>0</u>	<u>Patient Background Checks</u>	<u>60</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>TRUST/FRANCHISE/CONTRIB/ETC</u>	<u>4,090</u>	
				<u>EMPLOYEE BENEFITS - OTHER</u>	<u>597</u>	<u>MARKETING/ADV/PROMO</u>	<u>6,424</u>	
				<u>EMPLOYEE PHYSICAL EXAMS</u>	<u>615</u>	<u>LICENSES/DUES/SUBSCRIPTIONS</u>	<u>8,257</u>	
				<u>PENSION/PROFIT SHARING PLANS</u>	<u>0</u>	<u>MGMT CO ALLOC</u>	<u>1,088</u>	
				<u>CHICAGO HEAD TAX</u>	<u>0</u>	<u>TRUST/FRANCHISE/CONTRIB/ETC</u>	<u>(4,090)</u>	
				<u>INSURANCE - EXECUTIVE LIFE</u>	<u>0</u>	Less: <u>Public Relations Expense</u>	( <u>0</u> )	
				<u>INSURANCE - EXECUTIVE LIFE VI 21</u>	<u>0</u>	<u>Non-allowable advertising</u>	<u>(6,424)</u>	
						<u>Yellow page advertising</u>	( <u>0</u> )	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <u>233,408</u>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	\$ <u>289,432</u>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	\$ <u>14,275</u>	
<b>(List each licensed administrator separately.)</b>								
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
<u>ASTA HEALTHCARE MANAGEMENT , INC.</u>			\$ <u>180,000</u>			\$	<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	<u>0</u>
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$ <u>180,000</u>				<u>Seminar Expense</u>	<u>0</u>
<b>(Attach a copy of any management service agreement)</b>							<u>MGMT CO ALLOC</u>	<u>618</u>
C. Professional Services			TOTAL			TOTAL		
Vendor/Payee	Type		Amount			Amount		Amount
			\$			\$	<u>Entertainment Expense</u>	( )
							(agree to Sch. V, line 24, col. 8)	
							<b>TOTAL</b>	\$ <u>618</u>
<u>SEE SCHEDULE ATTACHED</u>			<u>53,993</u>					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <u>53,993</u>					
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1	PAINT/DECORATING	2005	\$ 1,757	3YRS	\$ 293	\$ 586	\$ 586	\$ 292	\$	\$	\$	\$								
2	PAINT/DECORATING	2006	2,457	3YRS		410	819	819	409											
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 4,214		\$ 293	\$ 996	\$ 1,405	\$ 1,111	\$ 409	\$	\$	\$								

Facility Name &amp; ID Number ASTA CARE CENTER OF ELGIN

# 0041608

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 HEALTHCARE ASSOC. \$5,630
- (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. \$ 16,207 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES \_\_\_\_\_ NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,998  
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